OUR VISION

We envision a system of care that promotes wellness and recovery by supporting clients with mental health and substance use disorders to pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM PILOT
SAN FRANCISCO IMPLEMENTATION PLAN
November 1, 2015

INTRODUCTION

Through participation in the California Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot program, the City and County of San Francisco seeks to transform the San Francisco Health Network-Behavioral Health Services (SFHN-BHS) substance use disorder (SUD) continuum of care to promote the wellness and recovery of individuals with substance use and related disorders. This will be accomplished by improving access to high quality, cost effective, sustainable SUD treatment and transitional care services.

San Francisco takes great pride in a deep and longstanding commitment to protecting and promoting the health of all residents through a comprehensive, integrated, consumer-driven system of care. Working in collaboration with community partners, the San Francisco Department of Public Health (DPH) is the lead public agency that safeguards and maintains the City's commitment to protect and promote the health of San Franciscans by providing a full array of services, supports, and resources to residents from prevention and early intervention to treatment and transition services.

As San Francisco's largest public agency, DPH has two major divisions: 1) Population Health; and 2) the San Francisco Health Network (SFHN). The SFHN encompasses most of the services covered by the DMC-ODS Pilot including Ambulatory Care (Primary Care, Behavioral Health Services (BHS), Maternal, Child and Adolescent Health, and Jail Health Services), San Francisco General Hospital, Transitions, Managed Care, and Laguna Honda Hospital (long-term care). The SFHN is the City's only complete care system that includes primary care for all ages, dentistry, emergency & trauma treatment, medical & surgical specialties, diagnostic testing, skilled nursing & rehabilitation, and behavioral health services.

Under the DMC-ODS Pilot, the SFHN-BHS will be responsible for the implementation of San Francisco's Implementation Plan in

partnership with DPH Population Health, consumers, public agency partners, and the SFHN-BHS network of community-based primary care and behavioral health providers. The SFHN actively engages consumers with health and behavioral health disorders in pursuing optimal health, happiness, recovery, and a full and satisfying life in the community.

The SFHN seeks to achieve this goal in part by applying "Quadruple Aim"[1] to behavioral health services through the lenses of cultural humility, wellness and recovery which includes: 1) improving the client experience of care (including quality and satisfaction); 2) improving the health of populations; 3) reducing the per capita cost of care; and 4) improving the behavioral health workforce.

The SFHN values the following aspects of behavioral health care which are consistent with the DMC-ODS Pilot approach to care:

1. A trauma-informed system of care that fosters wellness and resilience for everyone in the system, from our clients to the staff who serve them;
2. The practice of cultural humility where we make a consistent commitment to understanding different cultures and focusing on self-humility, maintaining an openness to someone else's cultural identity, and acknowledging that each of us brings our own belief/value systems, biases, and privileges to our work;
3. Whole Person Care that integrates both behavioral and physical care of a client including assessing the needs of a client's identified family and other significant relationships;
4. Colleagues who have experienced behavioral health challenges and bring their empathy and empowerment to recovery in others, as well as inspire and share their experience to create a truly recovery-oriented system;
5. Valuing all clients that seek our services;
6. Shared decision making in providing the best possible coordinated care, where clients and their providers collaborate as part of a team to make care decisions together.

Vision for System Transformation

The SFHN-BHS County Implementation Plan reflects the desired system transformation and practice change identified by the Centers for Medicare & Medicaid Services (CMS) in the approved California DMC-ODS Pilot. Major SUD system of care transformation and practice change elements include:

- Enhanced Benefit Design
  - Adoption of industry standard placement criteria reflected in the American Society of Addiction Medicine (ASAM) Criteria for level of care assessment and placement within residential treatment and exploring options for the integration of industry standards throughout the SUD continuum of care;
  - Support of additional Medication Assisted Treatment (MAT) including buprenorphine and methadone;
  - Use of evidence-based and local promising clinical practices and interventions;

[1] The "Quadruple Aim" is based on the IHI Triple Aim framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance.

- Provision of short-term residential care consistent with ASAM levels 3.1., 3.3, and 3.5;
- Enhanced system capacity for, recovery support services;
- Additional housing supports.

- SUD Provider Network Development
  - Technical assistance and support for existing providers to meet Drug Medi-Cal certification standards and requirements;
  - Infusion of trauma-informed care principles throughout the behavioral health treatment system;
  - Intensive technical support, training and assistance to SUD providers to improve practice and support the SUD workforce;
  - Enhanced program monitoring to ensure adherence to ASAM Criteria and DMC-ODS requirements;
  - Expansion of recovery supports and services such as transitional supportive housing.

- Care Coordination Enhancements
  - Use of the Screening, Brief Intervention and Referral to Treatment (SBIRT) screening tool in primary care settings (ASAM level 0.5);
  - Development of strategies to improve care transitions among levels of care including "warm hand-offs";
  - Recovery care management through primary care and behavioral health homes to manage client maintenance of well-being and recovery;
  - A memorandum of understanding with the San Francisco Health Plan that specifies protocols for coordination of care with managed care plans including information sharing, case management and collaborative treatment planning.

- Integration
  - Primary care and behavioral health integration including continued expansion of behavioral health homes across BHS Adult/Older Adult Systems of Care and eventually the Children, Youth and Family System of Care;
  - Assessment of co-occurring disorders and comorbidities;
  - Integrated care models including continued support for longstanding and newly formed partnerships with the criminal justice system;
  - The Sobering Center – a specialized emergency department diversion center with high quality nursing that offers medication for withdrawal pending admission to a more structured setting for intoxicated alcoholics brought by the San Francisco Police Department, ambulance, or homeless outreach, as well as those referred by the Emergency Department.

- Program Integrity
  - Enhanced compliance monitoring;
  - Provider screening and enrollment requirements to prevent fraud and abuse.

- Adolescents and Young Adults
  - Enhanced SUD treatment capacity;
  - Exploration of strategies for adoption of ASAM criteria for adolescent level of care standards and client placement;
  - Establishment of a behavioral health home in the Juvenile Justice Center
  - Compliance with Early Periodic Screening, Diagnosis, and Treatment requirements.

- Benefit Management
  - ASAM Criteria for assessment and level of care placement (residential treatment);
  - Enhanced utilization review process.

- Data Collection and Quality Measures
  - Enhancement of SUD contractor performance measures;
  - Additional SUD objectives in Annual Quality Improvement Work Plans;
  - Expansion of SFHN-BHS Quality Management staffing;
  - Full participation in UCLA DMC-ODS Pilot evaluation.

San Francisco: Unique Challenges

The City and County of San Francisco (CCSF) ranks as the 4th largest California city and ranks 14th largest in the United States with an estimated population of 852,469 as of July 1, 2014 (U.S. Census, 2015). Residents largely are adult with 83.7% over age 21, 13.8% of which are older adults over age 64. San Francisco is an ethnically and culturally diverse city with Non-Hispanic Whites (41.7%), Asians (33.1%), Hispanic (15.2%) and Black/African American (5.6%) residents compromising the majority of the population.

As a national leader in innovation, San Francisco is currently enjoying a boom economy, driven in large part by growth in the technology sector and technology workers who have chosen San Francisco as their residence. The corresponding growth in the local real estate market has resulted in community-based organizations and vulnerable residents losing long-term leases, forcing many to become homeless or become exclusively mobile in search of affordable rent. Limited real estate opportunities for treatment facilities also presents unique challenges Often buildings that may be available for residential and transitional supportive housing require substantial renovation and in some cases, present significant obstacles for disability access. Our system has sufficient capacity for timely admission to residential treatment; however supporting clients who have completed treatment in finding safe affordable housing once they are in recovery will remain a challenge, and require expansion of case management services. Our providers for the largest residential facilities own their buildings and are not threatened by prohibitive rents.

Related to housing affordability, San Francisco continues to lead the nation in income inequality, with continued growth in income disparity between wealthy households (95th percentile) and lower earning households (20th percentile), with wealthy households earning at least $423,000 annually and households at the 20th percentile earning just over $24,800 (Brookings Institution, 2015).

While economic growth has allowed for public investments in the behavioral health system, San Francisco's escalating cost of housing and leased property and growing income disparities have had a disproportionate impact on nonprofit community providers and the behavioral health clients they serve.

Health disparities and inequities continue to exist among San Francisco residents notwithstanding intentional investments to improve the health of all San Franciscans. In particular, health disparities continue among Black/African American residents. The DPH Black/African

American Health Initiative Project seeks to reduce this disparity across four priority health indicators including the mortality rates among Black/African American men due to alcohol.

In addition, there are neighborhoods within San Francisco – the Tenderloin, South of Market, and Bayview-Hunters Point neighborhoods – that far exceed the city and countywide rate and goal for preventable emergency room visits; San Francisco's large Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA) community is at two to three times the risk of substance use than the general population; and many substance use disorder treatment clients have faced homelessness, significant personal trauma, and serious health conditions as a result of not accessing medical care.

The DMC-ODS Pilot offers San Francisco the opportunity to mitigate economic inequities and health disparities by improving access to high quality, effective SUD treatment services, with the overall system goal of reducing emergency room visits and the use of high cost treatment services.

San Francisco: SUD Treatment Capacity and Drug Use Patterns and Trends

Treatment Capacity and Need

In Fiscal Year (FY) 2014-15, the SFHN-BHS served 7,388 unduplicated clients through the SFHN-BHS Children, Youth and Family (CYF) System of Care and Adult/Older Adult (A/OA) Systems of Care. On average, the SFHN-BHS serves 3,950 clients through SUD treatment programs each month.

The SFHN-BHS estimates that 24,293 Medi-Cal beneficiaries would meet the Diagnostic and Statistical Manual (DSM)-5 Substance Use Disorder diagnosis/medical necessity criteria for the DMC-ODS Pilot. Recent findings from the Substance Abuse and Mental Health Administration (SAMHSA) *2014 National Survey on Drug Use and Health* (NSDUH) found that the vast majority of individuals needing SUD treatment do not seek services. Using these NSDUH findings, the SFHN-BHS projects that 3,091 beneficiaries could access treatment services under the DMC-ODS Pilot. This includes 2,818 Medi-Cal beneficiaries (11.6% of San Francisco's 24,293 Medi-Cal beneficiaries) plus an additional 373 DMC eligible individuals who may have perceived a need for treatment but did not seek it due to a lack of health coverage/affordability which has now been eliminated as a barrier through expanded access to health insurance coverage.

Drug Use Patterns and Trends

According to the National Institute on Drug Abuse *August 2015 National Drug Early Warning System (NDEWS) Sentinel Community Site Profile for San Francisco*, alcohol and illicit substance use in general has remained relatively stable in the San Francisco though the NDEWS report noted a reduction in lifetime use of heroin and a reduction in ecstasy use reported by high school students from 2011 to 2013.

According to the NDEWS report, alcohol, opioid, methamphetamine and cocaine use remain the predominant substances impacting health outcomes for San Francisco residents.[2] The most frequent cause of admissions to substance use disorder treatment is alcohol, reflecting a quarter of

[2] National Drug Early Warning Center (NDEWS) Sentinel Community Site Profile 2015: San Francisco, August 2015, NDEWS Coordinating Center, Center for Substance Abuse Research, University of Maryland, College Park.

all treatment episodes. Additional findings from the NDEWS report included:[3]

- 61% of San Francisco residents reported past month use of alcohol;
- 25% of residents reported binge alcohol use;
- 13% of residents reported past month use of marijuana;
- 5% of residents reported past year non-medical use of prescription pain relievers;
- 12% of resident reported dependence or abuse of alcohol compared to 3% reporting dependence or abuse of illicit drugs;
- Among high school students, there was no statistically significant changes in substance use from 2011 to 2014, except for a significant reduction in lifetime use of heroin and ecstasy;
- Young adults, aged 18-25, had the highest prevalence for past month binge alcohol use and use of illicit drugs other than marijuana, past year cocaine and nonmedical prescription pain reliever use, and past year dependence or abuse of alcohol or illicit drugs;
- There has been a sustained increase in treatment admissions among adults for heroin each year since 2010 and in naloxone overdose rescue events which have increased fourfold since 2010 though there has not been a coinciding increase in heroin-related mortality;
- Use of stimulants overall remained stable with slight increase in methamphetamine use indicators and decreases in cocaine use indicators among the general population and persons who inject drugs (PWID), while men who have sex with men reported increased cocaine use and decreased methamphetamine use;
- Persons who inject drugs reported improved access to syringes from reliable sources and increased rates of safe syringe use;
- Hepatitis C virus remains common among PWID with an estimated prevalence of 53.5% though there were increased rates of Hepatitis C virus testing;
- Use of prescription opioids remained stable according to admissions to substance use disorder treatment due in part to significant reforms in prescribing that have led to a dramatic reduction in the availability of prescription opioids in the illicit market;
- Drug overdose (poisonings) deaths were stable through 2012 with approximately 18 deaths per 100,000 persons, though there were significant differences in death rates based on gender, race, and age: 1) the rate among men was higher (24.1) compared to women (10.9); 2) the rate among Black/African American residents was higher than others with 62.1, compared to White (25.2), Hispanic/Latino (10.3), and Asian persons (3.2); and 3) persons, aged 45-64, had the highest rate of drug-related deaths (46.4).

[3] National Survey on Drug Use and Health, Survey on U.S. Population, 2010-2012

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Appendix A - The ASAM Criteria ..... **Error! Bookmark not defined.**

Attachment B– Behavioral Health Services System of Care Quality Improvement Committee Member List ..... **Error! Bookmark not defined.**

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Appendix D – Memorandum of Understanding ..... **Error! Bookmark not defined.**

PART I - PLAN QUESTIONS

Summary of City and County of San Francisco's DMC-ODS Implementation Plan.

1. **Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.**

   - ✓ County Behavioral Health Agency
   - ✓ County Substance Use Disorder Agency
   - ✓ Providers of drug/alcohol treatment services in the community
   - ☐ Representatives of drug/alcohol treatment associations in the community
   - ✓ Physical Health Care Providers
   - ✓ Medi-Cal Managed Care Plans
   - ☐ Federally Qualified Health Centers (FQHCs)
   - ✓ Clients/Client Advocate Groups
   - ✓ County Executive Office
   - ✓ County Public Health
   - ☐ County Social Services
   - ☐ Foster Care Agencies
   - ☐ Law Enforcement
   - ☐ Court
   - ☐ Probation Department
   - ☐ Education
   - ☐ Recovery support service providers (including recovery residences)
   - ☐ Health Information technology stakeholders
   - ☐ Other (specify) _____

2. **How was community input collected?**

   - ✓ Community meetings
   - ☐ County advisory groups
   - ✓ Focus groups
   - ☐ Other method(s) (explain briefly):

3. **Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.**

- ✓ Monthly (internal implementation group convened by SFHN Substance Use Disorder Medical Director/County Alcohol and Drug Administrator)
- ☐ Bi-monthly
- ☐ Quarterly
- ✓ Other: In addition to monthly planning meetings, it is anticipated that the county implementation plan will be discussed in multiple forums including regular updates with the DPH Director's Office, the Ambulatory Care Steering Committee (oversight body comprised of senior SFHN managers), SFHN-BHS Executive Team (senior managers for the Children, Youth and Family System of Care and Adult/Older Adult Systems of Care), Quality Improvement Committee, and other bodies).

Review Note: One box must be checked.

4. **Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?**

- ✓ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.
- ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.
- ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
- ☐ There were no regular meetings previously, but they will occur during implementation.
- ☐ There were no regular meetings previously, and none are anticipated.

5. **What services will be available to DMC-ODS clients under this county plan?**

REQUIRED

- ✓ Withdrawal Management (minimum one level)
- ✓ Residential Services (minimum one level) – all three levels will be available
- ✓ Intensive Outpatient
- ✓ Outpatient
- ✓ Opioid (Narcotic) Treatment Programs
- ✓ Recovery Services
- ✓ Case Management
- ✓ Physician Consultation

How will these required services be provided?

- ☐ All county operated
- ✓ Some county and some contracted
- ☐ All contracted.

OPTIONAL

- ✓ Additional Medication Assisted Treatment
- ☐ Partial Hospitalization
- ☐ Recovery Residences
- ☐ Other (specify) _____

6. **Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?**

   - ✓ Yes (required)
   - ☐ No. Plan to establish by:_____.

   Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. **The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.**

   - ✓ Yes (required)
   - ☐ No

8. **The county will comply with all quarterly reporting requirements as contained in the STCs.**

   - ✓ Yes (required)
   - ☐ No

PART II - PLAN DESCRIPTION (Narrative)

City and County of San Francisco DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS reviews your plan description, you may need to make revisions.
- Counties must submit a revised plan to DHCS whenever the county requests to add a new level of service.

NARRATIVE DESCRIPTION

1. Collaborative Process

Collaboration and transparency are two core principles of the SFHN-BHS System of Care. In 2013, the SFHN-BHS first introduced the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver to community stakeholders through standing SOC and Substance Use Disorder (SUD) meetings with the goal of establishing a partnership with behavioral health providers in developing a comprehensive, client-centered continuum of care. Since that time, providers have been engaged at each stage of the development of the county waiver plan with an initial focus on improving the quality and availability of SUD services by meeting DMC certification requirements and increased coordination among systems of care through the implementation of behavioral health homes.

The SFHN-BHS has made several intentional capacity building investments to support DMC provider certification which include:

- Facilitating DMC solutions meetings between and among the County Alcohol and Drug Administrator and billing, contracting, compliance, cost reporting, and information systems staff;
- Hosting focus groups facilitated by the Director of Operations for contracting partners in preparation for new services and requirements under DMC;
- Facilitating a focus group with peers and consumer advocates with the Director Operations on “what is good care”;
- Participating in a monthly pain management work group for primary care and the San Francisco Health Plan to provide input on safe prescribing of opioids and OBOT buprenorphine in primary care clinics;
- SUD physician and SUD pharmacist participation on bimonthly MUIC and MQIC meetings to provide input on medication use initiatives and medical quality improvements respectively;
- Facilitating monthly medication-assisted treatment for alcohol group with Sobering Center, Treatment Authorization Program, and residential detox directors on how to improve medication-supported care for alcohol use disorders;
- Providing ongoing DMC technical assistance to providers;
- Hiring designated health program coordinator staff to support DMC certification and documentation requirements;
- Developing a SUD-DMC provider manual and certification and audit tools.

Future collaborative county waiver plan activities will include the alignment of SFHN-BHS treatment criteria with the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services, greater accountability for use of evidence-based practices, development of a continuum of care that includes all waiver required services, expanded consumer engagement including a, and development of measurable system, program and client level outcomes to improve service quality, access and cost efficiency.

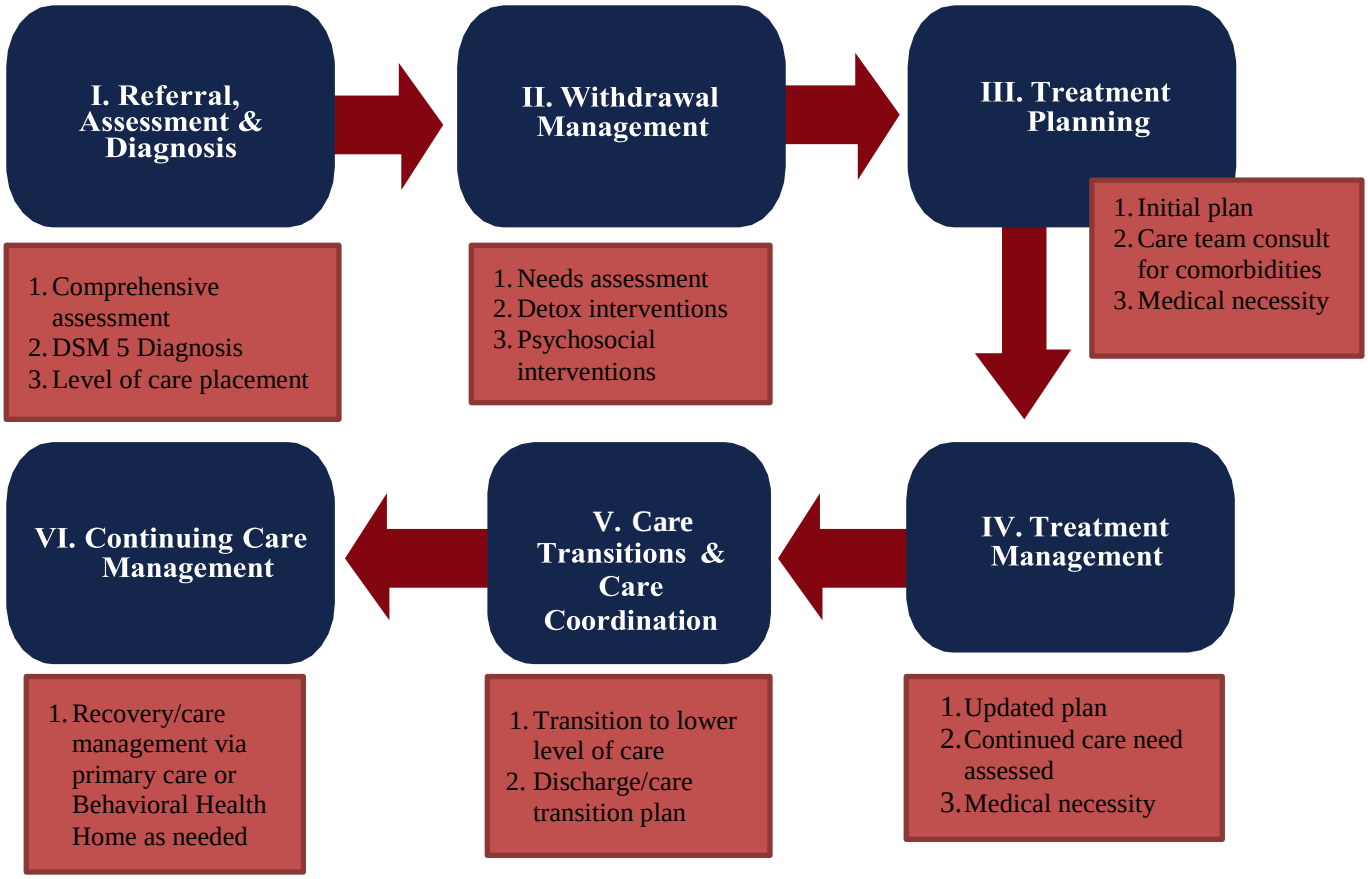
A partial list of standing collaborative meeting forums where the county waiver plan is discussed includes:

- Monthly SOC meeting which is a joint meeting between SFHN-BHS contracted mental health and substance use disorder providers;
- Monthly SUD provider meetings for CEOs and Directors;
- Monthly OTP provider meetings for methadone clinic directors;
- Weekly MH/SUD executive meeting with participation by the County AOD Administrator;
- Weekly medical executive meetings with participation by the SUD medical director; and
- Weekly prevention provider meetings with the prevention coordinator present.

2. Client Flow

Overview

Substance use disorders are a primary, chronic disease requiring long-term treatment to achieve recovery with relapse potential. The SFHN-BHS supports harm reduction, a public health philosophy that promotes reducing the physical, social, emotional, and economic harm associated with substance use, along with other harmful behaviors on individuals and their family and community. Clients are partners in their recovery process with regular assessments of progress to guide placement and care transition decisions. Please see the client flow diagram below.



Required Continuum of Care Component Description (Referral, Assessment, Authorization, Placement & Transitions)

Referral

The main designated point of access for SFHN-BHS SUD treatment services is the Howard Street Program which is an outpatient substance use disorder treatment clinic operated by DPH. The Howard Street Program contains four service components: 1) the Treatment Access Program (TAP) which supports walk-in, centralized intake, assessment, and referral/placement services, outpatient treatment, and the 24/7 toll-free behavioral health access line; 2) Office-Based Buprenorphine Induction Clinic which offers evaluation, placement and stabilization support for opioid treatment; 3) the BHS Pharmacy, which provides observed dosing and dispensing of methadone, buprenorphine and naloxone rescue kits, oral naltrexone, and access to injected

naltrexone and 4) the Offender Treatment Program which provides case management, counseling, mandatory urinary analysis and literacy, GED and employment counseling treatment services to non-violent offenders assigned by the courts who are on parole or probation and who use or possess drugs. In addition, SFHN-BHS SUD specialists are available for consultation with other providers for SUD assessment and treatment referrals.

Although the Howard Street Services Treatment Access Program is a centralized access program, and does utilization management of residential SUD services, the SFHN-BHS embraces a philosophy of care that supports any door as the right door to access appropriate treatment services. Clients may self-refer to treatment providers or be referred through other community access points such as behavioral health or primary care clinics.

Comprehensive Client Assessments

Howard Street TAP staff conduct the assessment of a client presenting for treatment. Howard Street TAP is staffed by Licensed Clinical Social Workers and Psychiatric Nurse Practitioners, who also provider supervision to Certified Drug Counselors and a Licensed Vocational Nurse. This assessment is usually same-day on weekdays, but may take up to 72 hours. This initial interactions is a screening/triage assessment, documenting the diagnosis and need for care, in particular dimension 1, ie need for withdrawal management or hospitalization. If care is immediately available, referral for care is prioritized, with further assessment, including ASAM criteria assessment would occur at the program site as part of intake within 72 hours of admission, and communicated to TAP electronically. If treatment is not immediately available, or if further assessment is required, the full ASAM assessment would be carried out at TAP within 72 hours. We expect Howard Street TAP to be the main central site for ASAM Multidimensional Assessment and for re-authorizations of each 30 days of residential care under the DMCODS Pilot. Some clients will have the full ASAM Assessment at the Howard Street TAP, others upon intake at the treatment program. If clients present to treatment sites directly, requesting residential treatment, ASAM Assessment can also be carried out by trained staff, either LPHAs or under LPHA supervision. This assessment is then communicated to TAP at Howard Street for authorization. This assessment will consider immediate needs of clients due to imminent risk for any of the six ASAM Multidimensional Assessment dimensions. Howard Street TAP manages supervised withdrawal beds and initiates medication for alcohol withdrawal treatment by prescriptions filled at the BHS pharmacy on site. Clients with opioid use disorders would be either referred to the Office-based Buprenorphine Induction Clinic onsite or referred to one of the methadone clinics for same-day admission to MAT. Administration of full ASAM assessment before referral to OTP would unnecessarily and adversely delay treatment admission to OTP.

OTP assessments. Even same-day full ASAM assessment at TAP would unnecessarily delay access to methadone first dose at OTPs by a full dangerous day. Further assessment once dosing has begun will elicit need for mental health and primary care service or in some cases residential admission with continued methadone dosing at the residential program.

For Methadone maintenance MAT clients, SUD treatment provider medical staff conduct assessment according to federal and state regulations. These are medical evaluation (or review and concurrence of a medical evaluation) for each client which includes: 1) a medical history, including the individual's history of substance use; 2) laboratory tests for determination of narcotic drug use, tuberculosis and syphilis; and 3) physical examination. Transition to levels of care within methadone maintenance follow federal and state regulations and include frequency of counseling as well as need for supervised dosing. Under current regulation, there is no

graduation to complete primary care methadone maintenance. Even clients judged to be stable for office-based care in primary care setting must remain enrolled in the parent OTP and have at least one observed dose per month at a DMC certified dispensing site. In California, there is also required minimum counseling, testing frequency and quarterly treatment plan requirement.
We do not plan to use ASAM criteria assessments routinely to authorize opioid treatment program placement. Admission and progress in treatment criteria are established strictly in regulation, and ASAM assessment would be trumped by those regulations. ASAM criteria do not distinguish at what point office-based MAT can replace OTP MAT, which could be a useful tool for buprenorphine treatment, and could help OTP providers move patients to primary care buprenorphine. The San Francisco system of care provides the induction and stabilization clinic (OBIC), where this distinction is made by physicians, social workers, clinical pharmacists and nurse practitioners as they work with each patient.
Adding ASAM multidimensional assessment as a requirement in OTP intake process would unduly slow admission and lower our current standard of same day access for OTP admission. Medical necessity for OTP admission is spelled out in the regulations. ASAM assessment will be provided as part of OTP treatment planning, within 30 days of admission, and will aid in determining further or higher levels of care that might be needed. For patients on buprenorphine who stabilize, transfer criteria will be used to decide to move to primary care/OBOT setting. Some OTPs may decide to administer ASAM assessment upon intake; others might do it later in the 30 day period. The essential deciding factor is to not delay treatment.

Non-residential assessments:
At the end of residential treatment we plan to use ASAM assessment to guide outpatient placement in level 1 or 2.1 as part of ongoing treatment and transition to community. We expect that eventually all programs would have capacity to administer ASAM assessment and obtain electronic authorization via TAP. Both TAP and residential programs have the ability to administer ASAM assessment. We expect it would be carried out by the residential treatment program as part of transition/transfer planning in most cases.
For all other non-residential treatment clients will be assessed by SUD treatment providers in compliance with pertinent state and federal regulations.
We hope eventual installation of ASAM assessment capability into the electronic record will allow ASAM Multidimensional Assessment to replace the current ASI evaluation, used as a treatment planning in outpatient programs. However, our EHR provider, Netsmart, has been refusing to incorporate ASAM, citing small market. Although clients are referred to outpatient care from TAP, it does not function as a central sole access center for outpatient care. Regardless of when our current EHR provider incorporates ASAM capability, we have begun the process of using the electronic form of ASAM assessment, separate from the Netsmart Avatar. Availability of this free-standing option will allow providers with diverse electronic records to use the electronic ASAM assessment.

<u>Authorization</u>
All residential treatment placements are authorized centrally through the Howard Street Services TAP staff which maintain up-to-date residential treatment slot capacity for the SFHN-BHS SUD treatment system (see Authorizations section for additional details). Prior authorizations for residential treatment are processed within 24 hours of a client presenting for treatment.

For non-residential treatment, TAP makes referrals to SUD treatment providers for clients that

access the SFHN-BHS treatment system via TAP. SUD treatment providers make determinations on treatment eligibility, following DMC and other alcohol and drug treatment requirements and standards for SUD treatment. Clients also may self-refer or be referred to non-residential treatment. Central prior authorization is not required for outpatient services.

Level of Care Placement and Reassessments

Using information from the comprehensive assessment conducted with clients, clients will be placed in the appropriate level of care at intake, taking into account client preferences and needs including the intensity of withdrawal services needed. Residential treatment will be reassessed and re-authorized at 30 days as required under the DMC-ODS Pilot.

Case Management

The SFHN-BHS supports a case management model that reflects a collaborative team-based approach to assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a client's comprehensive health and behavioral health needs. Essential to this model are regular team communication, trust and respect among team members for the role each is trained to play in client wellness and recovery, including peer support staff, and access to resources and supports needed to promote positive client outcomes and high quality, cost effective services. This includes access to needed medical, educational, social, prevocational, vocational, rehabilitative, and other community services.

The case management model supported by the SFHN-BHS is not linear and tailors case management services to client needs. Current SFHN-BHS SUD treatment programs offer case management services within each program, often undertaken by the drug counselor in cooperation with the treatment team. The DMC-ODS Pilot offers the SFHN-BHS the ability to provide off-site transitional and non-face-to-face services, potentially enhancing transitions care management and intensive case management (ICM). Currently, ICM is only available to SFHN-BHS clients with severe mental health challenges. Case management is also offered through the medical health plan for persons who show up in emergency departments, or who need help upon discharge with transition to community. In preparation for the DMC/ODS waiver, SFHN-BHS SUD is piloting ICM at Sobering Center, frequented by our most severe alcohol use disorder clients. If successful, this pilot would result in expanded access to this model for clients with primary SUD diagnoses that are having challenges engaging in treatment or wellness activities, and allow them to access services from acute SUD care settings that are not currently served by the mental health or physical health plans.

The SFHN-BHS also is in the process of implementing and evaluating a case management model through the establishment of Behavioral Health Homes within the SFHN-BHS Adult-Older Adult Systems of Care that uses a team-based approach to client case management. SUD treatment counselors participate as part of the BHH teams that manage panels of behavioral health clients with serious mental health challenges that have secondary addictive disorder diagnoses that interfere with healing and wellness. Although BHH model is not fully developed within SUD settings, there are three OTPs that offer primary care on site, and one residential care provider that also integrates psychiatry and FQHC medical home, allowing integrated team care. So far in California, SUD case management has been part of drug counseling and residential care, occurring within treatment programs; we are piloting transitions case management for identified extremely high risk persons with alcohol use disorder at sobering center. Many existing SUD programs already care for high-risk high utilizing persons with primary SUD diagnosis. For example our

NTPs have 15-25% homeless or marginally housed enrollees. Under DMC/ODS, we plan to introduce the new Case Management benefit at transitions of care of these beneficiaries. San Francisco Department of Public Health has developed an electronic record called Coordinated Case Management System (CCMS) that harvests information on use of multiple systems, including jail, county hospital, mental health, substance use, primary care, EMS. The substance use part of this record is siloed due to part 2 privacy constraints. The CCMS highlights the High Users of Multiple Systems (HUMS), and various efforts to target those persons for outreach and care coordination are made, often resulting in placement within SUD treatment programs, but such targeted CM outreach may or may not be provided through DMC/ODS, depending on results of the pilot. If part 2 privacy constraints and siloed case management notes are shown to nullify benefits of ICM, further development of CM within DMC programs will still continue. Any SUD services offered as part of the DMC/ODS pilot will include ASAM assessment. Whether offered by the county or by our contracting partners, the ASAM assessment will be carried out after documented training, either live or via the webinar trainings. We expect that licensed providers as well as certified drug counselors will become proficient in ASAM assessment. Ensuring proper use of ASAM assessment will be incorporated into county monitoring visits. Through the DMC-ODS Pilot, the SFHN-BHS will seek to apply knowledge and lessons learned through the BHH initiative to the SUD treatment system, working in partnership with SUD treatment providers to improve current case management practices by:

- Addressing the comprehensive needs of SUD clients including medical, psychosocial, behavioral, and spiritual needs;
- Partnering with clients to problem-solve and explore treatment options;
- Improving coordination of care and communication among members of the care planning team;
- Promoting client self-advocacy, self-care, and self-determination;
- Integrating peer support staff within treatment planning to share their knowledge, advocate for and support clients;
- Using industry standards of practice and guidelines such as ASAM Multidimensional Assessment;
- Proactively ensuring that transitions to other levels of care are effective, safe, timely and complete (“warm hand-offs”);
- Improving client safety and satisfaction;
- Helping clients reach their optimal level of health, well-being and recovery.

Case management services will be provided in full compliance with all client confidentiality requirements under federal and state law.

3. Beneficiary Access Line

The SFHN supports a toll-free 24/7 access line for clients and prospective clients to access behavioral health services including SUD treatment. The toll-free line is managed during business hours by SFHN Behavioral Health Access Center (BHAC) staff. After hours, the 24/7 access line is managed via contract by SF Suicide Prevention which is required to submit electronic call logs with call details to the BHAC Access Coordinator on a daily basis.
The numbers are: 24-Hour Access Helpline: (415) 255-3737 or (888) 246-3333 TDD (888) 484-7200. The suicide prevention line is**:** 415-781-0500 Interpretation services are made available in the language of the caller on an as needed basis. During the business hours, calls are triaged by Behavioral Health Access staff who speak the languages of the callers. If a caller speaks a language not spoken by access staff, the Language Line is used. During after hour calls, SF Suicide Prevention staff remain on the line with callers until a connection is made with the Language Line if needed.

All callers during business and after hours are screened for crisis situations and referred appropriately.

To measure the quality and responsiveness of the 24/7 toll-free access line, the SFHN-BHS Quality Improvement Work Plan contains an "Access to Care" goal that incorporates the following performance benchmark: All calls to the BHS 24/7 toll-free access line will be answered by live service providers in the language of the caller and will gather all required information to ensure the caller receives the appropriate information or referrals needed.

The data sets below are collected and reviewed by the BHAC Access Coordinator. Using this data, the Access Coordinator monitors the quality and responsiveness of calls and discusses needed improvements in weekly staff meetings. The Access Coordinator reviews and monitors business hours and after hours calls for appropriate handling and provides immediate feedback to SF Suicide Prevention about improvement needs. In addition, SF Suicide Prevention staff receive ongoing training and a written protocol on phone answering and are provided updated computerized call logs. The Access Coordinator also conducts one to two test calls per month to the after-hour call center and logs the results of these calls.

Indicators	Standards of Excellence
Number of Rings	<5 rings
Answered as SFBH Access	Y
Staff Name Provided	Y
Caller's Name Asked	Y
Language Used	Listed
Wait Time for Interpretation	<5 minutes
Waited or Checked In Often	Y
Client or 3rd Party	C or 3
Assessed for Crisis	Y
Live in SF?	Y or N
Asked about Insurance	Y or N/A
Referral Offered	Y or N/A
Referral Provided	Y or N/A
Call Back Offered	Y or N/A
Provider List Requested?	Listed
Grievance Form Requested	Listed

Call Log Number/Treatment Access	Listed

In keeping with SFHN-BHS support for consumer-driven care, behavioral health consumer volunteers conduct two independent test calls per month, one during business hours and one after hours, to monitor the quality of calls triaged by BHAC staff. The results of the calls are provided to SFHN-BHS Quality Improvement (QI) staff and shared with the BHAC Access Coordinator within 24 hours of the test call. SFHN-BHS QI staff also meet monthly with the BHAC Access Coordinator to discuss and document improvements made in response to test call results.

On a quarterly basis, the SFHN-BHS Quality Improvement Committee reviews data on the availability, quality and responsiveness of the 24/7 toll free access line in client prevalent languages, along with any actions taken to improve quality.

4. Treatment Services

SFHN-BHS Philosophy of Care

Throughout the SFHN-BHS, we envision a system of care that promotes wellness and recovery by supporting clients with mental health and substance use disorders to pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources. In support of this vision, San Francisco values the following aspects of care:

- A trauma-informed system of care that fosters wellness and resilience for everyone in the system, from our clients to the staff who serve them;
- The practice of cultural humility where we make a consistent commitment to understanding different cultures and focusing on self-humility, maintaining an openness to someone else's cultural identity, and acknowledging that each of us brings our own belief/value systems, biases, and privileges to our work;
- Whole Person Care that integrates both behavioral and physical care of a client including assessing the needs of a client's identified family and other significant relationships;
- Colleagues who have experienced behavioral health challenges and bring their empathy and empowerment to recovery in others, as well as inspire and share their experience to create a truly recovery-oriented system;
- Valuing all clients that seek our services;
- Shared decision making in providing the best possible coordinated care, where clients and their providers collaborate as part of a team to make care decisions together;
- Integration of prevention, early intervention, education, outreach, and engagement within the continuum of care.

Our philosophy of care embraces the "Quadruple Aim" approach to optimizing system performance by improving the client experience of care (including quality and satisfaction), improving the health of populations, reducing the per capita cost of care, and striving for workforce excellence. SUD treatment services reflect harm reduction, a public health philosophy that promotes reducing the physical, social, emotional, and economic harm associated with drug and alcohol use, along with other harmful behaviors on individuals and their community. Harm reduction is free of judgment or blame and actively engages clients in setting their own treatment goals and their recovery.

DMC-ODS Pilot Required Treatment Services

All of the required DMC-ODS Pilot SUD treatment and recovery services will be offered. Most of these services are not currently DMC funded or certified. This will be the main priority between now and full implementation of the pilot. Please see summary tables on following pages which include:

- A description of available services by ASAM level of care;
- The number of current SUD treatment providers by ASAM level of care;
- Current treatment capacity by ASAM level of care; and
- Future system capacity goals under the DMC-ODS Pilot to address systemic challenges.

ASAM Level of Care	ASAM Level Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
0.5	**Early Intervention (falls under medical health plans, not directly provided by BHS/SUD)**	**Screening, Brief Intervention, and Referral to Treatment (SBIRT)** *Screening by primary care physicians, brief behavioral counseling interventions, and referrals to behavioral health treatment services to clients at risk of SUD, aged 18 and older.*	• Twelve (12) Primary Care Clinics - Adults and Children • Eleven (11) Primary Care Clinics – Teenagers/Young Adults Only	• SBIRT training provided to staff • Medi-Cal requirement for primary care	1. Continue to support primary care in SBIRT training, and monitoring of referrals.
1	**Outpatient Services**	**Outpatient Drug Free** *Recovery or motivational enhancement therapies/strategies less than 9 hours a week (adults) and less than 6 hours a week (adolescents).* <u>Service Components</u>*:* a) Intake b) Individual & Group Counseling c) Patient Education d) Family Therapy e) Medication Services f) Collateral Services g) Crisis Intervention Services h) Treatment Planning i) Discharge Services	• Five (5) SUD Outpatient Treatment Providers under Children, Youth, and Family (CYF) System of Care • Eight (8) SUD Outpatient Treatment Providers under Adult/Older Adult (A/OA) Systems of Care	• Capacity to serve 9,396 unduplicated SUD clients in outpatient drug free, intensive outpatient and case management services	1. Support Outpatient programs in becoming DMC certified. 2. Expand SFHN-BHS CYF System of Care capacity to provide outpatient services to adolescents through mental health civil service clinics that serve teenagers and young adults and school-based mental health partnerships. 3. Increase SFHN-BHS CYF and A/AO system capacity to provide SUD intensive outpatient services through establishment of SFHN-BHS CYF Behavioral Health Homes. 4. Develop, implement, and evaluate strategies to address identified challenges to service access (neighborhood clinic locations, cultural specificity of programs) 5. Explore flexible transitions between IOP and ODF, taking into account patient preferences, legal obligations, housing status, etc.
2.1	**Intensive Outpatient**	**Intensive Outpatient** *Structured programming services to treat multidimensional instability not requiring 24-hour care for a minimum of 9 or more hours with a maximum of 19 hours a week (adults) and 6 hours or more with a maximum of 19 hours (adolescents).* Service Components: see Outpatient Drug Free.	• Three (3) SUD Intensive Outpatient Treatment Provider under A/OA Systems of Care (all three are DMC certified)		

ASAM Level of Care	ASAM Level - Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
3.1	**Residential Services**	***Residential Services*** *24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.* Service Components: a) Intake b) Individual & Group Counseling c) Patient Education d) Family Therapy e) Safeguarding Medications f) Collateral Services g) Crisis Intervention Services h) Treatment Planning i) Transportation Services (to/from medically necessary treatment) j) Discharge Services	• Seven (7) providers under A/OA Systems of Care with multiple service sites • No SUD residential treatment providers under CYF System of Care, one program with limited availability in Alameda County.	• 370 ASAM Level 31., 3.3, and 3.5 residential treatment beds under A/OA Systems of Care (levels not yet confirmed by DHCS or county monitors, but declared by programs on DHCS website) • Specialized residential treatment for pregnant and post-partum women including program offering perinatal outreach and comprehensive case management for homeless women • In preparation for the DMC-ODS waiver, we expect all our residential contracting partners to become DMC approved by the state. Many already have done so, and others are in process. Once our county waiver is fully approved, we plan to roll out gradual DMC billing, after it's clear that each program is capable of the increased documentation standards. Meanwhile, we provide these services, but supported by county funding pending DMC billing start. These contracting partners are already serving Medicaid beneficiaries. • No residential SUD treatment beds for adolescents, limited availability in one program in Alameda County	1. Subject to passage of AB 848, develop residential treatment program with medical withdrawal management for homeless clients including medications for alcohol withdrawal over 5-day period with 24/7 RN supervision. 2. Identify strategies to provide short-term residential treatment to adolescents served under the CYF System of Care, possibly by regional agreement with Alameda County or new RFP.
3.3	**Residential Services**	**Residential Services** *24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.* Service Components: see list above under ASAM Level 3.1			
3.5	**Residential Services**	**Residential Services** *24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.* Service Components: see list above under ASAM Level 3.1			
ASAM	**ASAM Level**	**Service Description**	**Number of Providers**	**Current System Capacity**	**Future System Capacity Building**

Level of Care	- Service				Goals
	Narcotic Treatment Program (NTP)	**Narcotic (Opioid) Treatment Program** *Daily or several times weekly opioid agonist medication and counseling available for those with severe opioid disorder including methadone, buprenorphine, naloxone, and disulfiram.* Service Components: a) Intake b) Individual and Group Counseling c) Patient Education d) Medication Services e) Collateral Services f) Crisis Intervention Services g) Treatment Planning h) Medical Psychotherapy: one-on-one counseling conducted by the Medical Director with the client i) Discharge Services	• Nine (9) NTP providers under A/OA Systems of Care, all dispense methadone, with exception of county-supplied buprenorphine for pregnant women when appropriate at one NTP.	• Capacity to serve 3,683 unduplicated SUD clients • No waiting list – 275 open slots available (DATAR, 12/31/14)	1. Add buprenorphine as a DMC-benefit within NTP care when DHCS regulations completed. 2. Develop spoke and hub model for buprenorphine care between NTP and primary care clinics.
1-WM	**Withdrawal Management**	**Withdrawal Management** *Mild withdrawal with daily or less than daily outpatient supervision.*	• Six (6) providers under A/OA Systems of Care (14 methadone clinic locations)	• Opioid withdrawal available through methadone clinics as methadone detox. • Buprenorphine tapers available as needed. • Medically supervised outpatient alcohol withdrawal available for safely housed clients.	1. Develop DMC benefit for non NTP MAT at Howard Street Program (if successful, expand benefit and possibly RFP).
3.2-WM	**Withdrawal Management**	**Withdrawal Management** *Moderate withdrawal with 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.*	• Two (2) residential SUD providers funded under A/OA Systems of Care • One (1) Sobering Center, providing 24/7 RN supervision under medical protocols for intoxicated alcoholics brought by ambulance, police, homeless outreach, or referred by the Emergency Department (ED). This is a sobering center, diversion from ED, not an SUD treatment program.	• 62 detox beds under SUDA/OA Systems of Care • No waiting list - six (6) open slots available (DATAR, 12/31/14)	1. Develop and enhance medically supervised withdrawal, post passage of AB 848. 2. Support DMC certification of the two residential providers. 3. Pilot and evaluate placing ICM at Sobering Center.

ASAM Level of Care	ASAM Level - Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
4.0-WM ***3.7**	**Withdrawal Management**	**Withdrawal Management** *24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical history.* **3.7- or close to it- is available in hospital diversion Sobering center and residential medical detox. Both provide round the clock nursing supervision, with oral medications for withdrawal. Most of these could be managed as outpatient MSW if the clients were safely housed. Both have access to hospital (4.0) admissions when necessary.*	• San Francisco General Hospital via SFHN Primary Care because this DMC benefit is not available for emergency admissions, we are not able to access this benefit.	SFGH has many emergency admissions for medical effects of addiction, including accidents, infections, and seizures. The hospital has a sophisticated alcohol detox protocol, including ICU care for delirium and follow-up naltrexone on discharge for alcohol use disorder. The hospital has buprenorphine and methadone 'starts', as well as continuation for opioid use disorder with coordinated discharge to methadone clinic or Howard Street OBIC.	1. If Sobering ICM pilot is successful, expand to include hospital discharges with addictive disorder diagnoses that required withdrawal management with prompt step down from level 4 to level 3.5 residential with medication management of withdrawal.
	Additional Medication Assisted Treatment (MAT)	**Additional MAT** *Daily or several times weekly alcohol agonist medication and counseling available for those with severe alcohol use including acamprosate, naltrexone, disulfiram, and topiramate.*	• Twelve (12) SFHN Primary Care • Eight (8) SFHN-BHS A/OA Systems of Care Mental Health clinics • San Francisco General Hospital • Jail Services/Sheriff's Department	<u>Alcohol MAT</u> • Alcohol medications including naltrexone, acamprosate, disulfiram, and off-label use of topiramate <u>Methadone MAT</u> • Three (3) methadone outreach vans • Seven clinics contract with 25 programs. • Continued treatment in jail • Enhanced perinatal support • Maintenance and detoxification • Hospital starts • Primary care methadone OBOT • Facilitated entry from outreach to homeless • Centralized after-hours intake <u>Naloxone MAT</u> • Pilot project for police officers to	1. Continue to increase use of long-term alcohol treatment medications, include initiation within residential treatment, post AB848 – in particular the detox residential programs. 2. Continue to increase prescribing and distributing naloxone rescue to clients with opioid use disorder at all SUD sites.

				carry naloxone • Community naloxone and syringe distribution <u>Buprenorphine MAT</u> • Integrated buprenorphine model into primary care and mental health clinics • Support for buprenorphine induction at Howard Street Program • BHS Pharmacy contributes observed dosing and medication advice by specialized clinical pharmacist • BHS pharmacy provides medication for uninsured patients and for OBIC patients during stabilization • Buprenorphine “starts” in jail • Hospital buprenorphine “starts” with expedited placement at Outpatient Buprenorphine Induction Clinic • Hospital naltrexone starts/brief interventions for hospitalized patients who have alcohol withdrawal management – continuation in primary care upon discharge • Buprenorphine integrated into residential care and residential detoxification.	

ASAM Level of Care	ASAM Level - Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
	Recovery Services	**Recovery Services** *Community-based recovery and wellness services provided face-to-face, by telephone or by telehealth with the client to support transfers/transitions. The following services may be provided to clients whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.* Service Components: a) Individual and Group Outpatient Counseling to stabilize clients and reassess if further care is needed; b) Recovery Monitoring: recovery coaching, monitoring via telephone or internet; c) Substance Abuse Assistance: peer-to-peer services and relapse prevention; d) Education and Job Skills: linkages to life skills, employment services, job training and education services; e) Family Support: linkages to childcare, parent education, child development support services, family/marriage education; f) Support Groups: linkages to self-help and support, spiritual and faith-based support; g) Ancillary Services: linkages to housing assistance, transportation, case management, individual services coordination.	• Six (6) providers operate network of assisted self-help centers, independent living, and recovery/sober living residences in high need neighborhoods under the A/OA Systems of Care • San Francisco Drug Relapse Prevention Line (24/7 phone access to trained staff)	• Relapse prevention counseling available to all clients through SUD treatment providers • 80 transitional sober housing slots tied to outpatient treatment with readmission to detox or residential in case of relapse • Drop-in center with walk-in harm reduction groups	1. Explore DMC certification in the context of recovery support services. 2. Provide system-wide training on Wellness & Recovery Model including appropriate recover monitoring in primary care. 3. Provide consultation services to SUD providers through SFHN-BHS Wellness and Recovery Coordinator's Office 4. Develop, implement and evaluate recovery services model for relapse prevention 5. Expand access to peer coaching and support services through integration of peer support workers within team-based care model. Current system has peer navigation for enrollment into Medicaid, and peer re-entry support after residential treatment. Peer recovery support specialists are used in the collaborative dependency court. Coordination and expansion of peer services and training is being developed as part of the workforce development during the DMC/ODS expansion. Part of this training is to further define the service, and include DMC-specific documentation standards for these peer services.

					6. Explore opportunities to fully integrate SUD recovery services within CYF and A/OA Systems of Care mental health clinics with high percentages of clients with co-occurring disorders 7. Capture lessons learned from Behavioral Health Homes to improve availability of effective recovery services for clients with co-occurring disorders

ASAM Level of Care	ASAM Level - Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
	Case Management	**Case Management** *Services that assist a client in accessing needed medical, educational, social, prevocational, rehabilitative, or other community services and focus on coordinate of SUD care, integration around primary care and interaction with the criminal justice system if needed.* Service Components: a) Comprehensive assessment and periodic reassessment of individual needs for continuation of case management b) Transition to a higher or lower level SUD of care c) Development and periodic revision of a client plan that includes service activities d) Communication, coordination, referral and related activities e) Monitoring service delivery to ensure client access to service and service delivery system f) Monitoring client's progress g) Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services	• All (45) providers offer case management services under SFHN-BHS CYF and A/OA Systems of Care	• NTP primary counselors provide case management • Transitional intensive care management pilot for chronic inebriates who do not access treatment and use many acute medical services	1. Continue to develop and implement team-based care and case management model under Behavioral Health Homes for adoption system-wide. 2. As above, evaluate ICM pilot at Sobering and spread if appropriate.
	Physician Consultation	**Physician Consultation** *Physician-to-specialist consultation by network physicians, with addiction medicine physicians, addiction psychiatrists, addiction specialist NPs, or specialist clinical pharmacists to support SUD treatment plans for clients with complex needs. Includes: medication selection, dosing, side effect management, adherence, drug-drug interactions, and/or level of care considerations.*	• Physician consultation available by phone and email, staffed by SFHN-BHS SUD Medical Director • Pharmacy 'drug information line' available by phone at Howard Street BHS pharmacy, staffed by clinical pharmacist with SUD specialization. • SUD specialty NP available by phone, email and onsite training on Buprenorphine MAT at 1380 Howard OBIC.	• All requests for consultation addressed • Informs training needs and protocol development, and improvement projects. • •	1. Develop DMC benefit 2. Explore need for tracking.

ASAM Level of Care	ASAM Level Service	Service Description	Number of Providers	Current System Capacity	Future System Capacity Building Goals
	Intersection with Criminal Justice Population	**Criminal Justice System Partnerships** *Additional services tailored to needs of criminal justice population including:* a) Staff training and education that parole and probation status not a barrier to expanded DMC SUD treatment services (Federal Financial Participation restrictions apply to period when clients are incarcerated or detained only); b) Additional lengths of stay for withdrawal and residential services (e.g. up to 6 months for residential, 3 months FFP with one-time 30-day extension if found to be medically necessary); c) Use of promising practices such as Drug Court services.	Participation in San Francisco Diversion Courts: • San Francisco Drug Court (non-violent drug offenders and individuals with property charges driven by addiction) • Offender Treatment Program (non-violent, adult offenders who use/ possess drugs) • Behavioral Health Court (individuals with persistent mental illness or co-occurring disorders whose mental health issues contribute to their arrest) • Community Justice Center (individuals with misdemeanor/ felony offenses including SUD treatment in Tenderloin, SOMA, Union Square and Civic Center neighborhoods) • Youth Treatment and Education Center (youth involved or formerly involved in juvenile justice system) • Parole Re-Entry Court (parole violators with history of mental health and/or SUD) Criminal Justice Population Specific SUD Treatment and Services: • Two (2) NTP providers under A/AO Systems of Care (jail-out methadone maintenance clinics) • One Jail courtesy dosing provider under A/OA Systems of Care • One Drug Court Treatment Center under A/OA Systems of Care • Two outpatient providers under A/OA Systems of Care	• Residential: 20 SUD and 10 MH slots • Intensive Day Treatment: 10 slots • Low Intensity Day Treatment and Sober Living Environment: 10 slots • Low Intensity Day Treatment (3 days per week): 10 slots • Medi-Cal enroller located at Howard Street Program Treatment Access Program, to help facilitate enrollment for those eligible • Access to MAT and alcohol detoxification at county Jail Health Services • Buprenorphine bridge and enrollment at Howard Street Program	

Out-of-County Collaboration with Opt-Out Counties

Fifty-three California counties including San Francisco have opted in to participate in the DMC-ODS-Pilot over four phases. All San Francisco Bay Area counties have opted in which will reduce the likelihood of disruption of services from out-of-county beneficiaries seeking SUD treatment services in this region. This does not minimize financial reimbursement and treatment capacity issues that currently exist among opt-in counties.

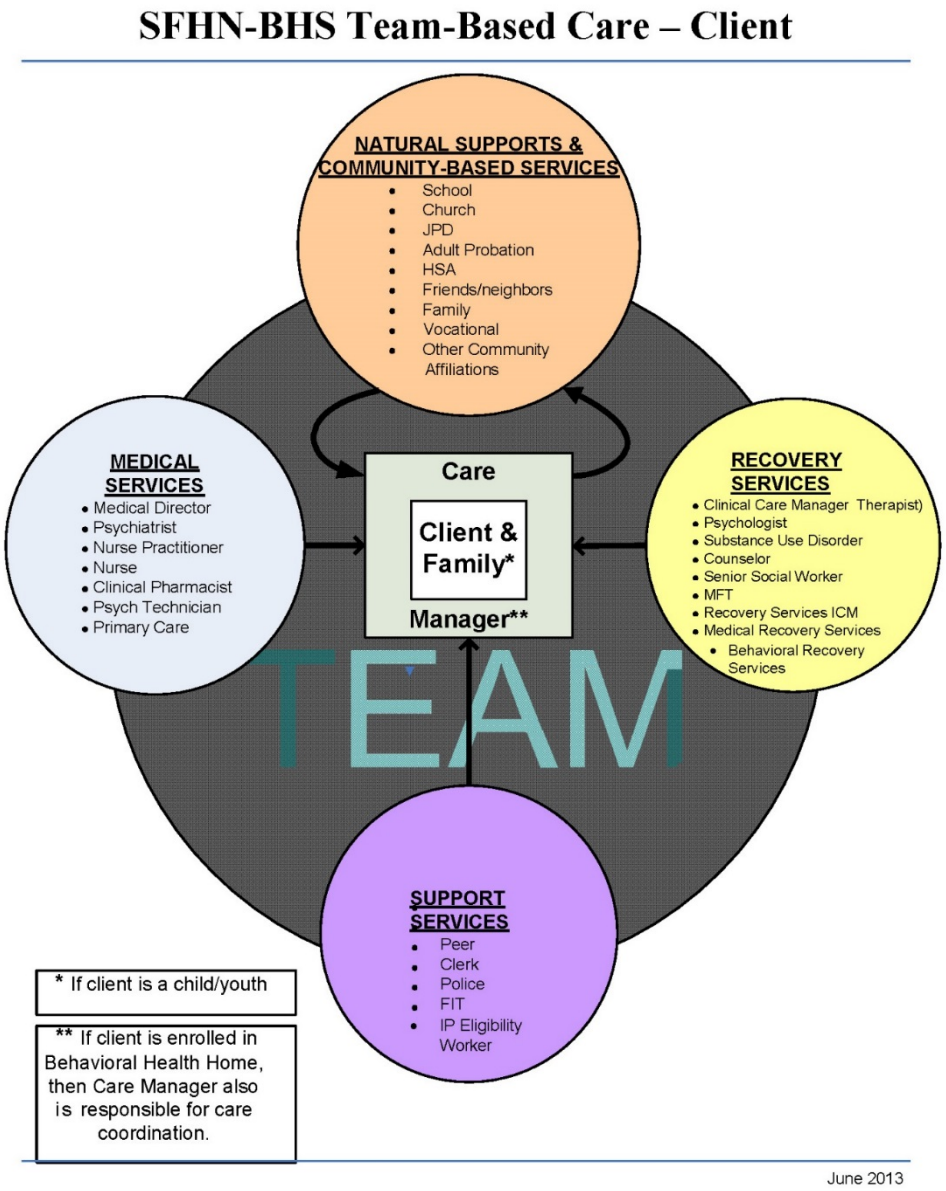
Currently, the SFHN-BHS serves out-of-county residents from Alameda, Contra Costa, and San Mateo Counties in its Narcotics Treatment Programs and accesses residential treatment programs in Alameda County for San Francisco clients. While a regional model is not being utilized by Phase I counties under the DMC-ODS Pilot, Bay Area counties have been engaged in regular discussions during the development of county implementation plans. While our regional plans for smooth transitions for out-of-county clients have not been completely finalized, we expect that programs would contract with DMC-ODS health plans in counties of residence of their clients. Some larger programs already do serve clients insured by other non-Medi-Cal health plans and are familiar with this process. At the county level, DMC-ODS monitoring by the county of service would be accepted by partnering counties.

One promising model of cross county and cross agency collaboration, the Children, Youth, and Family System of Care under the SFHN-BHS currently collaborates with Bay Area counties, as well as other placement counties, to ensure children, adolescents, and transition age youth, aged 18-21 years, involved in the child welfare system have timely access to needed behavioral health services (*Katie A.).* This collaboration could model effective regional approaches and strategies to care including care management models and financing mechanisms to reimburse counties for care provider to out-of-county youth.

One residential dual diagnosis capable program for youth, located in Oakland, serves most of the Bay Area counties. We expect to contract with this program, in cooperation with Alameda County. This is the only out of county residential service. The Bay Area Counties continue discussion on enhancing youth services. We don't expect to require out of county adult residential capacity. Reauthorization and time-limit specified in the waiver will open up beds, and in effect expand our current capacity. Addition of case management will support effective utilization, eliminating empty beds, and also in effect expand our capacity. We will continue to contract with one youth residential program in Oakland. It is undergoing renovation and new management, but we have received cost estimates from Alameda County for our budget.

5. Coordination with Mental Health.

The San Francisco Health Network is a comprehensive care system that includes primary care for all ages, dentistry, emergency & trauma treatment, medical & surgical specialties, diagnostic testing, skilled nursing & rehabilitation, and behavioral health services. Mental health and substance use disorder services are integrated under SFHN-BHS. As part of a system-wide effort to improve coordination between mental health, substance use disorder and primary care services, the SFHN-BHS has implemented Behavioral Health Homes (BHHs) in the SFHN-BHS Adult/Older Adult Systems of Care with the goal of establishing BHHs within the Children, Youth and Family System of Care. The BHHs manage and coordinate all of the services behavioral health clients receive, treating the whole person through a person centered, team-based care model. See diagram below. Although BHHs are not part of Drug medi-Cal, the SUD services provided at BHHs fills a gap for seriously mentally ill clients who are having trouble stabilizing due to co-occurring SUDs.



The BHH is not a place. It is a model for helping people with chronic conditions manage those conditions better by integrating and coordinating all primary care, acute, behavioral health and long-term services and supports to treat the "whole person." Chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Not all BHH services are provided at one site. However, BHHs are required to ensure that clients link to needed services and supports not available onsite.

Specific BHH services include comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow up, client and family support, and referrals to community and social support services.

The SFHN-BHS BHH model promotes the wellness and recovery of individuals with serious and persistent mental health conditions so that they may lead healthy and meaningful lives in their communities. The model seeks to accomplish this through team-based, person-centered care that includes clients, their support systems, and providers. This approach integrates medical and behavioral healthcare, recognizing the importance of caring for the "whole person". Team-based care incorporates the following principles:

- **Shared goals:** The team—including the patient, and where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities and can be clearly articulated, understood, and supported by all team members.
- **Clear roles:** There are clear expectations for each team member's functions, responsibilities, and accountabilities which optimize the team's efficiency and often makes it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.
- **Effective communication:** The team prioritizes and continuously refines its communication skills; it has consistent channels for candid and complete communication which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals.

Teams regularly evaluate their progress toward the shared goals and work together with clients and their family members to refine and move toward achievement of team goals. The goal of the SFHN BHH model is to identify those clients with serious mental health challenges who are unable to access primary care services due to disorganization associated with mental illness and substance use disorders, homelessness, or lack of effective supports, and who have poor self-management of medical and psychiatric conditions. The BHH team partner with clients to help link them to primary care, social, and community support services through coordinated care management and the promotion of self-management behaviors grounded in wellness and recovery education and support that eventually lead to a transition to a higher level of recovery (e.g. a lower level of care such as their medical home/primary care provider). While the currently existing BHHs serve only clients with severe mental health disorders and are not DMC-funded, they

provide and will provide information that guides DMC-ODS Pilot implementation.
We are exploring use of this model within Opioid Treatment Programs, for patients with primary opioid use disorder, with challenges accessing needed mental health or primary care.
In our county, mild to moderate mental health treatment is accessible through the medical health plan. The safety net primary care clinics have embedded behaviorists to assist with mental health and SUD evaluations and referrals.

6. Coordination with Physical Health.

The SFHN-BHS SUD treatment system currently integrates behavioral health and primary care through a number of services and programs in addition to Behavioral Health Homes.

Each BHH clinic site has a SFHN primary care (PC) community clinic partner to support an integrated, holistic approach to client care that meets both the behavioral health and physical health needs of BHH clients. Each BHH care model team includes, among others, an out-stationed PC nurse practitioner to assess and meet the physical health needs of BHH clients – some of whom have not accessed medical care through a primary care clinic – and a health worker to support the medical services. Both the nurse practitioner and health worker are staff of the partner PC clinic, and the primary care services provided at the BHH will be through a satellite clinic of the PC clinic.

For most BHH clients who are unable to access medical care through a PC medical home, physical health needs are met through the BHH clinic site. However, for those BHH clients whose physical health may be at a level of acuity and complexity that require ancillary services, they are supported to attend clinic visits at the PC partner site until the client's care can be safely managed at the BHH.

Additional SFHN-BHS physical health integration strategies include:

- The overall wellness and recovery model in the SFHN-BHS includes a marker of wellness for SUD clients that includes the ability to manage illness in primary care;
- SUD consultation services are provided to primary care;
- Primary care methadone is provided;
- Physicians at three clinic sites order methadone with counseling provided on site;
- Jail Health Services provides medically supervised withdrawal and buprenorphine MAT and coordinates ongoing methadone treatment during incarceration;
- MAT is provided to hospitalized clients at San Francisco General Hospital, with bridges to ongoing care as described above;
- SUD treatment is provided to clients admitted for medical rehabilitation at Laguna Honda Hospital through a consultation service - many of these clients have had brain injuries and trauma resulting in physical disabilities;
- Buprenorphine is prescribed by qualified physicians at primary care clinics, and each clinic has more than one DEA-waived physician able to prescribe buprenorphine;
- Patients starting on buprenorphine at the Howard Street Office-based Buprenorphine Induction Clinic or who require more intensive monitoring can receive their medication from the SFHN-BHS Pharmacy where pharmacists work closely with patients and prescribers to coordinate care, monitor for changes in psychiatric symptoms, assess substance use, and support adherence.
- One large SUD program also contains three FQHC primary care clinics able to coordinate care with residential and outpatient services including ongoing MAT with buprenorphine;

- Primary care is offered in methadone clinics:
  - Four of the methadone clinics offer significant medical care on site;
  - One NTP clinic offers HIV positive prevention and antiviral dosing;
  - One NTP clinic treats hepatitis C and has a hepatitis support group;
  - Two NTP clinics have a primary care medical home on site.
  - One NTP clinic offers enhanced treatment support during pregnancy and first two years postpartum for pregnant opioid-dependent patients on MAT with buprenorphine or methadone.

7. Coordination Assistance.

The SFHN-BHS would welcome the development of a professional learning community to explore strategies for improving cross-system capacity to better manage the coordination and tracking of client referrals and care, and in particular, enhancing care coordination during client transitions to other levels of care and cross-system communication on client care while maintaining client privacy protections. For example, although the SFHN-BHS can list services, it is challenging to track referrals among substance use disorder services and primary care and mental health services, because the electronic SUD services records are firewalled and sequestered by programs to meet Part 2 privacy restrictions. This can be particularly dangerous for MAT patients being considered for opioids or benzodiazepines in primary care or mental health settings. It also makes intensive case management difficult: although it is not treatment, and as such might not be Part 2 protected, there is no accepted non-MH or non-physical health case management electronic record that is DMC-compatible.

8.

Access

Access to All Service Modalities

The SFHN-BHS currently funds, supports, and oversees a broad network of 26 community-based SUD treatment providers that support over 90 treatment programs and sites across San Francisco. This diverse network of providers offers all of the required DMC-ODS Pilot treatment services, even though many of these programs are not currently DMC certified. In addition, the SFHN-BHS funds a community network of 11 prevention providers offering SUD evidence-based and local promising prevention services to middle school age students, high school age students, transition age youth, and families. Early intervention services – SBIRT screening and intervention – can be offered through SFHN primary care clinics with support from the SUD treatment system in training staff on SBIRT.

The SFHN-BHS also supports Medication Assisted Treatment services above and beyond DMC-ODS Pilot requirements, focused on identifying and providing treatment services to chronic homeless inebriates, a priority SUD treatment service population.

In addition to SUD treatment providers, a significant SFHN-BHS access point for SUD treatment services is through services offered at or referrals made by the broad, community based network of behavioral health and primary care clinics. This includes an extensive network of civil service behavioral health clinics in the Children, Youth and Family and Adult/Older Adult Systems of Care, High School Wellness Programs at all public high school sites, and 33 primary care clinics that serve both adults and adolescents throughout San Francisco, among other contracted providers.

As important as ensuring that required SUD treatment modalities are available is providing timely access to SUD treatment services for clients. The SFHN-BHS has made great strides in providing timely access to treatment services for SUD clients. For example, Opioid Medication Assisted Treatment is available as a walk-in, same day service, and SFHN-BHS SUD treatment services are located in areas of San Francisco with the greatest client residence density (see Geomap under Quality Assurance section of plan). In addition, public transportation access is available throughout San Francisco and in neighborhoods where the client residence density is high.

When there is a waiting list for services (primarily residential treatment), short-term outpatient treatment services are offered to clients until a culturally and geographically appropriate treatment slot becomes available. For example, at the Howard Street Program where many clients access residential treatment, up to 120 days of outpatient drug-free treatment is offered to clients waiting for residential treatment. On average, the duration of time that residential treatment clients are on waiting lists is less than 14 days. The SFHN-BHS will continue to reduce annually the duration of wait time for residential treatment by increasing the number of residential treatment and recovery housing slots.

DPH SFHN-BHS also has multiple long-standing public agency partnerships with the San Francisco Drug Court and the criminal justice system to meet the behavioral health needs of incarcerated inmates in the Jail including residential treatment, low intensity day treatment/sober living environment slots, and low intensity day treatment.

One challenge is the complex SUD treatment needs for the large homeless population in San Francisco. Many homeless clients are high acuity clients with multiple service and support needs

in addition to SUD treatment. This includes providing access to safe, affordable shelter and housing in one of the nation's highest cost real estate markets. Two primary strategies will be implemented under the DMC-ODS Pilot to support wellness and recovery of homeless clients:

- An effort will be made to expand system capacity to provide residential and transitional supportive housing services. With limited availability of affordable housing and appropriate facilities in San Francisco, this will be challenging. However, serving the homeless population is a high priority shared across multiple City and County agencies. The DPH Homeless Outreach Team, or HOT, provides services at homeless encampments. The medical director of HOT is a primary care physician with ABAM board certification. This means that homeless persons have access to specialty addiction care, including MAT, where they are, even before being sheltered or housed. The DPH HOT is not a DMC program; it is part of the SFHN Transitions section.
- The SFHN-BHS will integrate improved case management practices within the SUD treatment system through a team-based, person-centered care model that partners with clients and other service providers to ensure "warm handoffs" from and to the different ASAM levels of care, with the goal of eventually transitioning high acuity homeless clients to outpatient treatment as they progress in their treatment goals and safe, supportive housing becomes available.

In addition to meeting the needs of our client that are homeless, the SFHN-BHS will improve language and disability access for clients. Residential treatment sites often are located in converted older buildings with limited wheelchair access. The SFHN-BHS will develop cost effective, innovative strategies in partnership with the SUD treatment providers to improve disability access under the DMC-ODS Pilot and ensuring providers comply with SFHN-BHS disability access policies.

Current SUD Treatment Capacity

From Fiscal Year (FY) 2013-14 to FY 2014-15, there was a modest increase in available residential and residential detox beds in the SFHN-BHS. There also was an increase in available treatment slots for clients served through Outpatient Drug Free, Day Treatment/Intensive Outpatient, Case Management, and Narcotic Replacement Therapy. Please see table below.

FY 2013-14 & FY 2014-15 Availability of Substance Use Treatment in San Francisco

Modality	FY 2013-14	FY 2014-15	Increase
Residential	328 beds	370 beds	+42 beds
Residential Detox	59 beds	62 beds	+3 beds
Outpatient, Day Treatment, Case Management	9,330 unduplicated clients	9,396 unduplicated clients	+66 unduplicated clients
Narcotic Replacement Therapy	3,616 unduplicated clients	3,683 unduplicated clients	+ 70 unduplicated clients

Based on California Drug Abuse Treatment Access Reporting data pulled on December 31, 2014, there were no waiting lists for residential detox services or Narcotic Replacement Therapy in San Francisco. For residential treatment, 35 clients were waiting for placement and an additional 9 clients were waiting for outpatient, day treatment, and case management services. At the same time, there were 31 available residential slots and 12 available slots for outpatient, day treatment and case management services. The simultaneous existence of open slots and a waiting list was due to the neighborhood locations, cultural specificity of programs and client preferences, as well as the time delay between client notification and client registration.

Under the DMC-ODS Pilot, the SFHN-BHS will seek to increase treatment capacity for residential and transition and recovery services over the next three years to meet DCM-ODS Pilot requirements to support a more robust aftercare and recovery service system and meet client demand for SUD residential treatment.

Current SUD Treatment Utilization

The SFHN-BHS serves 3,950 clients on average in SUD treatment programs each month. This includes new and existing clients (please see graph on the following page which show SUD treatment trends from July 2013 through June 2015). In FY 2014-15, 7,388 unduplicated individuals were served through the CYF and A/OA Systems of Care.[4] Below is a table that shows numbers served by age group.

FY 2014-15, Number of SFHN-BHS SUD Treatment Clients, Aged Birth – 64, n=			
0-11 years	**12-17 years**	**18-25 years**	**26-64 years**
31 clients	301 Clients	452 Clients	6,591 Clients

Anticipated Number of Medi-Cal Clients

In August 2015, 125,729 individuals were enrolled in Medi-Cal Managed Care in the San Francisco Health Plan (CCSF Medi-Cal Plan).[5] The SFHN-BHS estimates that 24,293 Medi-Cal beneficiaries would meet DSM 5 SUD diagnosis/medical necessity criteria for DMC-ODS Pilot treatment services:[6]

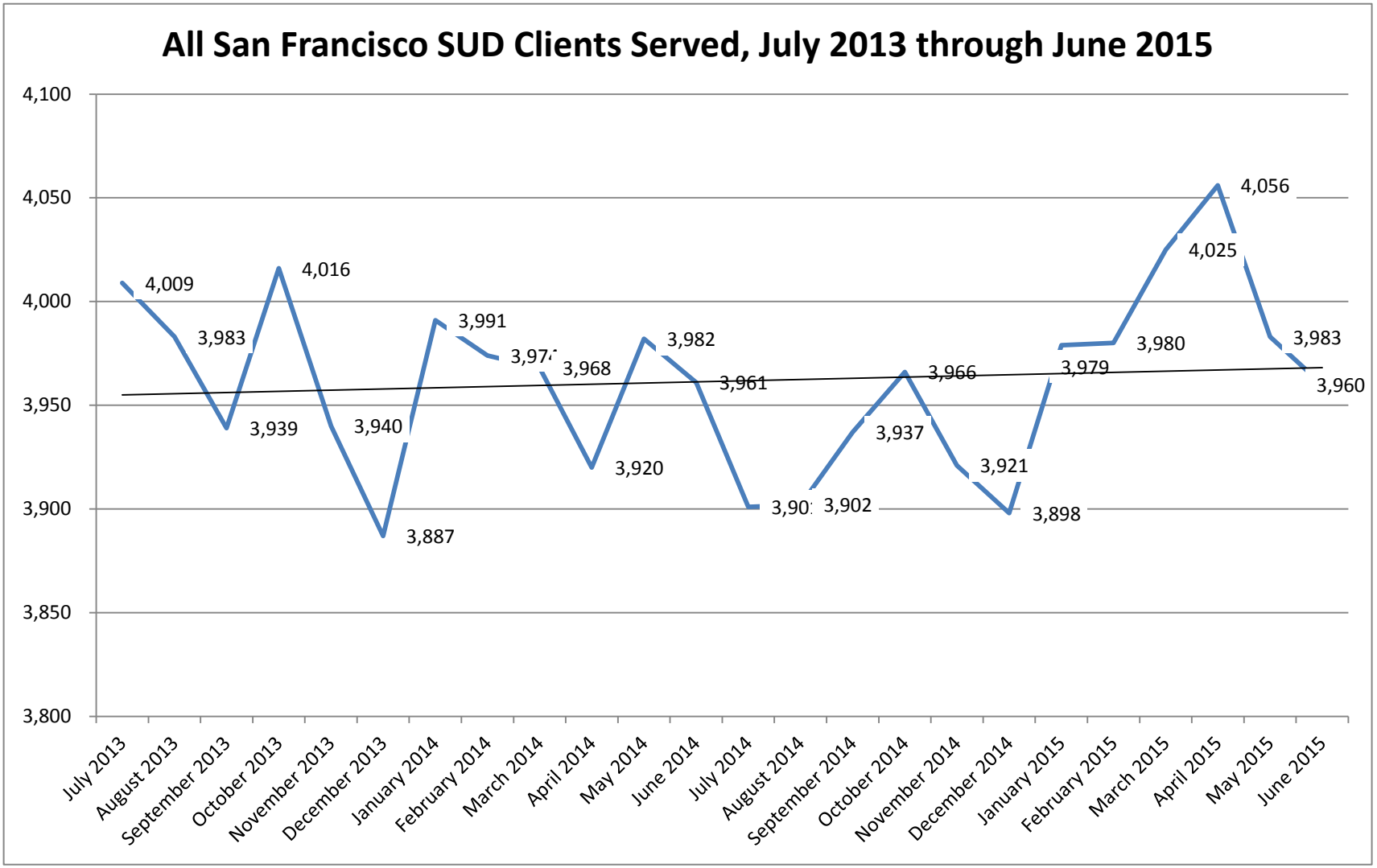
- 16,204 current Medi-Cal beneficiaries, aged 18 and older (12%);
- 3,589 current Medi-Cal beneficiaries, aged 18 and under (6.1%);[7]
- 4,500 uninsured individuals newly eligible under the New Adult Group (15%).

[4] Total does not include 13 clients for whom age data was not recorded.

[5] DHCS Monthly Managed Care Capitation Report, August 2015, San Francisco County.

[6] The Centers for Medicare and Medicaid Services (CMS) estimates that 12 percent of adult Medicaid beneficiaries, aged 18-64, have an SUD and 15% of uninsured individuals who could be newly eligible for Medicaid coverage under the New Adult Group have an SUD, July 27, 2015, State Medicaid Director Letter.

[7] The Centers for Medicare and Medicaid Services (CMS) states that 6.1 percent of adolescents, aged 12 to 17, were classified as substance abusive or dependent, January 26, 2015, Joint CMCS and SAMHSA Informational Bulletin.


All San Francisco SUD Clients Served, July 2013 through June 2015
4,100
4,050
4,000
3,950
3,900
3,850
3,800
4,009
3,983
3,939
4,016
3,940
3,887
3,991
3,968
3,920
3,982
3,961
3,902
3,937
3,966
3,921
3,898
3,979
3,980
4,025
4,056
3,983
3,960
July 2013
August 2013
September 2013
October 2013
November 2013
December 2013
January 2014
February 2014
March 2014
April 2014
May 2014
June 2014
July 2014
August 2014
September 2014
October 2014
November 2014
December 2014
January 2015
February 2015
March 2015
April 2015
May 2015
June 2015

Expected Utilization of Services

As mentioned in the Introduction, based on data recently published in the Substance Abuse and Mental Health Services Administration, *2014 National Survey on Drug Use and Health (NSDUH)*[8], the vast majority (88.4%) of individuals, aged 12 and older, needing SUD treatment for a problem related to the use of alcohol or illicit drugs did not receive treatment in a specialty facility.[9] Additional NSDUH findings included: 1) treatment access rates youth with an SUD, aged 12-17, were lower than young adults, aged 18-24, and adults, aged 26 and older; and 2) only 4% of those who needed, but did not seek treatment, perceived a need for treatment.

The most cited barrier to treatment access cited by those who perceived a need for SUD treatment but who did not receive treatment was not being ready to stop (41.2%), or 2 of 5 individuals were not ready to enter treatment. Our approach to this is outreach, motivational interviewing at health intersections, and ICM for those who are suffering most. San Francisco already provides community-based harm reduction approaches to drug and alcohol user health, including syringe access, naloxone rescue training and supplies, HIV and Hepatitis testing, and wound care for needle related skin infections. It is unclear how much these services would increase demand for SUD treatment.

The second most cited barrier was no health coverage and could not afford treatment (31.8%). This barrier is largely non-existent in San Francisco safety net, because most low income clients qualify for Medi-Cal. We provide SUD services, including MAT, to uninsured persons through Healthy San Francisco, and we enroll those appropriate for Medi-Cal.

Based on NSDUH survey data, the SFHN-BHS projects 3,091 DMC-ODS Pilot eligible individuals, aged 12-64, would access SUD treatment services. Please see analysis below.

- 2,818 clients would seek SUD treatment (11.6% x 24,293 beneficiaries); plus
- 373 eligible individuals who perceive a need for treatment could seek treatment as the health coverage/affordability barrier is eliminated through expanded access to health care insurance (88.4% x 24,293 beneficiaries x 4% x 31.8%).

While NSDUH findings were used in calculating projected SUD treatment utilization rates, the SFHN-BHS recognizes that there are unique local factors that will impact access to treatment services such as a large homeless population. Expanding access to supportive housing and residential programs where treatment can be integrated as a service will be challenging in San Francisco given the very limited availability of affordable real estate for additional treatment facilities and transitional housing.

The SFHN-BHS also recognizes that SUD treatment access rates for young adults, aged 18 to 25, are lower than those for youth, aged 12-17, and adults, aged 26 and older.[10] This

[8] SAMHSA, September 2015.

[9] A total of 20% received SUD treatment but this included those who did not meet the DSM SUD diagnosis criteria and participated in self-help groups and other services received through primary care or mental health clinics to maintain abstinence from alcohol or illicit drug use.

[10] The 2014 NSDUH reported that rates of SUD treatment access for those in need of treatment were lower for transition age youth and young adults, aged 18 to 25 (5.6% received treatment), than those aged 12-17 (7.9% received treatment), and those 26 and older (10.1%

engagement challenge also exists for mental health treatment. Developing strategies to extend "warm handoffs"/transitions to young adults as they transition from the Children, Youth and Family System of Care behavioral health treatment system to the Adult/Older Adult Systems of Care will be important to meeting their treatment needs. This is particularly important given estimated substance use and dependence rates for young adults of 18.9%.[11]

Hours of Operation of Providers

All providers are required to prominently post hours of operation at SUD treatment sites. SUD treatment services are generally provided Monday through Friday, from 9:00 a.m. – 5:00 p.m., with the exception of 24-hour service such as residential treatment. Narcotic Treatment Programs often have earlier hours. For example, NTPs have an eight-hour day, beginning at 5:30 a.m. or 7:00 a.m., and provide dosing hours staffed by nurses on weekends. In addition to accessing behavioral health clinics throughout San Francisco during these hours of operation, clients can self-refer/walk-in to access SUD treatment services at the DPH Howard Street Program. A 24/7 Telephone Access Line also is staffed by San Francisco Suicide Prevention via contract for after hours and weekend treatment access.

Language Capability for the County Threshold Languages

The SFHN-BHS threshold languages include Cantonese, English, Spanish, Russian, Tagalog, and Vietnamese. All SFHN-BHS SUD treatment providers must comply with the SFHN-BHS Cultural and Linguistic Competency Requirement for Behavioral Health Services Policy. This policy requires that providers have qualified bilingual staff who can communicate directly with clients in their preferred language as a first preference. If qualified bilingual staff are not available, the second preference is for other qualified bilingual, contract or volunteer staff be available to communicate face-to-face in a client's preferred language. As a last preference, access to language services are provided through the 24/7 Telephone Access Line. Materials in writing that explain county policies are posted in threshold languages. Front desk workers use an 'I speak' card when they find they cannot communicate verbally, to determine client language needs.

In addition, all SUD treatment providers are required to assess and report annually to the SFHN their ability to provide culturally and linguistically appropriate services as listed in CLAS standards

Notwithstanding these requirements, the large number of languages preferred by San Francisco clients often requires the allocation of substantial provider resources for interpretation and translation services. The SFHH-BHS will continue to work with SUD treatment providers in improving language capacity of the treatment network including exploring an expansion the current list of qualified bilingual staff that are available to support client language needs.

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accessed treatment).

[11] The Centers for Medicare and Medicaid Services, January 26, 2015, Joint CMCS and SAMHSA Informational Bulletin.

The Numbers and Types of Providers Required to Furnish the Contracted Medi-Cal Services

In addition to HIV testing, outreach and targeted case management services, the following table summarizes the number of contracted treatment providers and programs by ASAM Level of Care. The main current challenge facing these providers since 2013 has been becoming DMC certified. Training in DMC documentation and in use of ASAM criteria has begun, and we expect intensified TA and training in these areas over the next year.

ASAM	ASAM Level Service	Number of Providers
0.5	**Early Intervention (SBIRT)**	• Twelve (12) Primary Care Clinics - Adults and Children • Eleven (11) Primary Care Clinics – Teenagers/Young Adults Only
1	**Outpatient Services**	• Five (5) SUD Outpatient Treatment Providers under Children, Youth, and Family (CYF) System of Care/6 programs plus Wellness Centers at all public high schools • Eight (8) SUD Outpatient Treatment Providers under Adult/Older Adult (A/OA) Systems of Care/12 programs
2.1	**Intensive Outpatient**	• Three (3) SUD Intensive Outpatient Treatment Provider under A/OA Systems of Care
3.1, 3.3, 3.5	**Residential Services**	• Seven (7) providers under A/OA Systems of Care/23 programs • No SUD residential treatment providers under CYF System of Care
	Narcotic Treatment Program	• Nine (9) NTP providers under A/OA Systems of Care/14 methadone clinic locations & 2 mobile vans
1-WM	**Withdrawal Management**	• Six (6) providers under A/OA Systems of Care/14 methadone clinic locations
3.2-WM	**Withdrawal Management**	• Two (2) residential providers funded under A/OA Systems of Care • One (1) provider under A/OA Systems of Care providing 24/7 RN supervision under medical protocols for intoxicated alcoholics brought by ambulance, police, homeless outreach, or referred by the Emergency Department
3.7-WM	**Withdrawal Management**	• One (1) provider
	Additional Medication Assisted Treatment (MAT)	• Twelve (12) SFHN Primary Care Clinics • Eight (8) A/OA Systems of Care Mental Health clinics
	Recovery Services	• Six (6) providers operate a network of assisted self-help centers, independent living, and recovery/sober living residences in high need neighborhoods under the A/OA Systems of Care • San Francisco Drug Relapse Prevention Line (24/7 phone access to trained staff)
	Case Management	• All providers offer case management services under CYF and A/OA Systems of Care
	Physician Consultation	• Physician consultation available by phone and email, staffed by SFHN-BHS SUD Medical Director
	Intersection with Criminal Justice Population	Participation in San Francisco Diversion Courts & Criminal Justice Population Specific SUD Treatment and Services: • San Francisco Drug Court (non-violent drug offenders and individuals with property charges driven by addiction) • Offender Treatment Program (non-violent, adult offenders who use/ possess drugs) • Behavioral Health Court (individuals with persistent mental illness or co-occurring disorders whose mental health issues contribute to their arrest) • Community Justice Center (individuals with misdemeanor/ felony offenses including SUD treatment in Tenderloin, SOMA, Union Square and Civic Center neighborhoods) • Youth Treatment and Education Center (youth involved or formerly involved in juvenile justice system) • Parole Re-Entry Court (parole violators with history of mental health and/or SUD) • Two (2) NTP providers under A/AO Systems of Care (jail-out methadone maintenance clinics) • One (1) Jail courtesy dosing provider under A/OA Systems of Care • One (1) Drug Court Treatment Center under A/OA Systems of Care • Two (2) outpatient providers under A/OA Systems of Care

Timeliness of First Face-to-Face Visit, Timeliness of Services for Urgent Conditions and Access to After Hours Care

The SFHN-BHS Quality Management Program includes SFHN-BHS SUD services and monitors the timeliness of services on a quarterly basis, including time from request for service to first offered appointment, to first face to face appointment, and to first NTP service. The QMP also monitors timeliness of urgent services. Each program is required to document any request for service in the electronic Timely Access Log, which includes a checkbox for whether the service request if for an urgent need. The first offered appointment is documented in the Timely Access Log. Once the client completes the initial visit, time from initial contact to first face-to-face service, including first NTP service, is calculated.

The accuracy of our timely access analyses is dependent on the quality of the Timely Access Log completion. To ensure quality data, a dashboard report was developed to monitor the completion of the Timely Access Log, both at the system and program level, with the indicator being that the number of entries on the Timely Access Log should be greater than or equal to the number of service episodes open. The QI Committee also develops and reviews quarterly reports on our progress in meeting our timely access standard. The Directors of the Adult and Child Systems of Care take these reports back to their providers for discussion and follow up in cases where standards are not being met.

The QI Committee also reviews quarterly the timeliness of services for urgent conditions, based on the identification of the service need as being "urgent" on the Timely Access Log. The standard for urgent services is that the initial appointment should occur within 24 hours of the request for services.

Timeliness of afterhours care is monitored by obtaining the call logs of our crisis services (Comprehensive Crisis Services).

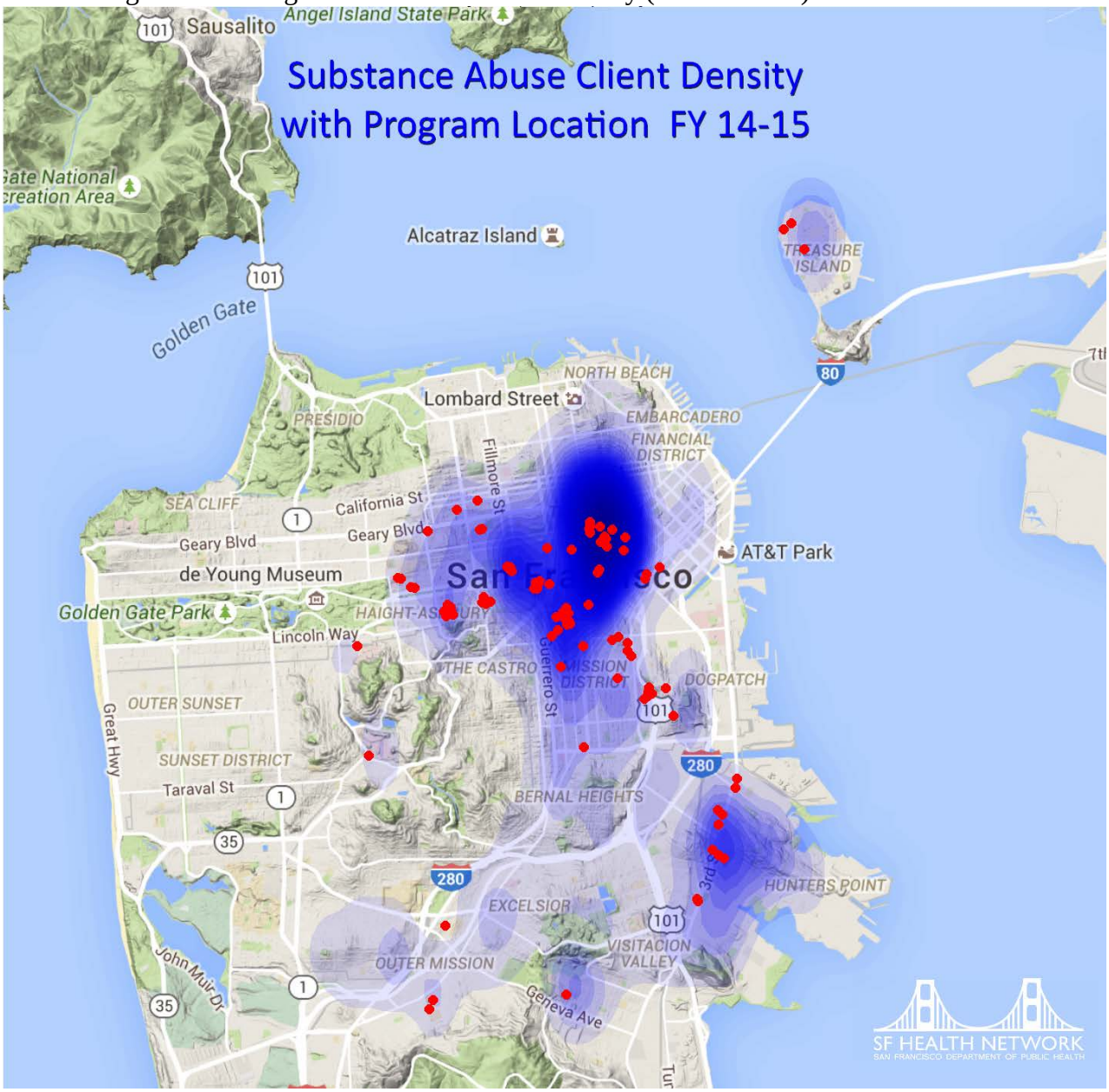
In addition to the required timely access indicators, the QMP also assesses quarterly the time from psychiatric hospital discharge to first follow up appointment, and to first medication appointment, including time to such appointments in Substance Use Disorder programs. Furthermore, we assess quarterly the psychiatric re-hospitalization rates for clients being treated in SUD programs. Reducing re-hospitalizations is a program performance objective for BHS programs. These reports are broken out by demographic categories of ethnicity, age, and gender.

The SFHN-BHS AOD administrator must submit a yearly report to the Board of Supervisors on the demand and access to substance use treatment.

The timeliness requirement from any contact marked ‘urgent’ is 24 hours to first or follow-up service. For non-urgent, there is same day engagement/orientation on weekdays for outpatient, with assessment to follow. The timeliness standard for outpatient care is maximum of 10 days from initial request to face to face visit, and 30 days from initial face to face visit to full assessment. For OTP, standard is same day admission and same day first methadone dosing on weekdays, with next workday admission on weekends and holidays. At the Treatment Access Program, screening is done weekdays upon walk-in, same day admission to detox, further assessment over 3 days to one week for residential treatment. Timeliness standard for residential treatment is 15 days from initial contact to first face to face service.

Geographic Location of Providers and Medi-Cal Beneficiaries

As part of the Quality Improvement Plan, the QMP produces geomaps of the location of substance use treatment programs by modality, overlaying a client residence density map. The geomaps are presented and discussed annually in the Quality Improvement Committee meeting, with a focus on ensuring that services are located in the areas with the highest client density. For clients who may live outside of the city center, San Francisco's public transportation options are plentiful and clients can easily access any services within the 7-mile by 7-mile radius of the City. The following FY 2014-15 Geomap demonstrates that the SFHN-BHS has SUD treatment services (dark red) that are well aligned with the greatest client residence density (medium blue).



9.

Training Provided

Since 2013, the SFHN-BHS has planned on opting into the DMC-ODS Pilot and has been training accordingly. The DMC-ODS requires a major workforce development and training component. Three main threads of the SFHN-BHS technical assistance and training occurring related to the DMC-ODS Pilot include: 1) DMC certification requirements and application/remediation support to programs; 2) DMC compliance and documentation with manuals and monitoring tool; and 3) ASAM criteria use in authorization of services. Training related to evidence-based care has long been a focus, as well as trauma-informed care and cultural competency and humility. In addition, San Francisco funds designated City and County behavioral health staff within the University of California, San Francisco to provide part-time support to providers on evidence-based practices.

The SFHN provides technical assistance and training to SUD treatment providers and will fully leverage available training resources from DHCS and other training providers including the California Institute for Behavioral Health Solutions and the Addiction Technology Transfer Center Network, and the discount on webinar training provided through ASAM on ASAM criteria.

All providers offering SUD treatment services under the DMC-ODS Pilot will be required to participate in SUD trainings or certify to the City and County that staff have completed the same or comparable training as evidenced by staff training completion certificates, training attendance sheets, and other written documentation.

Following is a table that summarizes current SUD trainings and frequency of trainings.

Training Topic	Participants	Frequency	Comments
Motivational Interviewing	• SUD Treatment Provider Staff • Primary Care Staff • Behavioral Health Provider Staff	Annually, ongoing	UCSF and SFGH participate in the SAMHSA SBIRT residency training, and we have local skilled trainers in our network. Challenge is to document fidelity of this EBP.
Buprenorphine Training	• Primary Care and Behavioral Health Physicians • Nurse Practitioners • Pharmacists • Psychosocial Providers	More than annually	UCSF Psychiatry and primary care residents are routinely trained, so typically there are multiple waiver trainings. In addition, there are specific trainings for mental health providers, and for primary care providers regarding pain management intersection with MAT.

Training Topic	Participants	Frequency	Comments
DSM 5 / ICD 10 Training	• SUD Treatment Provider Staff	Major push in FY 2014-15 with multiple day-long trainings; Expect annual trainings for several years.	San Francisco adopted DSM 5 in March 2015, preceded by intensive training. It is unclear how much future training will be needed.
Substance Use Disorders Training	• Interns • Primary Care Behaviorists	Annually	Training for psychosocial providers throughout our system
ASAM Criteria Training	• SUD Treatment Staff • BHS Administrators	Ongoing since 2013, expect very intense requirements in FY 15-16	ASAM criteria training becomes a credentialing requirement for SUD treatment staff in the DMC-ODS implementation. Although plans are not complete, we would expect that 300 SUD staff will take the two, five-hour webinars or the overview webinar by July 2016. Many programs already have the textbook, and residential programs have been asked to identify their ASAM levels.
DMC Documentation Training	• DMC Certified Programs	Three training days before July 2016; documentation manual developed in FY 2014-15	Many of our existing programs have not previously been DMC certified and need to learn Title 22 requirements.

Training Topic	Participants	Frequency	Comments
CLAS Standard Training	• All SUD Program Directors and Compliance Officers	Yearly, with special 0ne-day training planned in December 2015.	Although CLAS standards have been in contracts, they have not been closely monitored. Our cultural competency/workforce development director provides yearly TA that includes a yearly training
Drug Counselor Certification Course	• DPH staff wishing to become certified, peers, open to the public to register	Ongoing	SFHN-BHS subsidizes a counselor training course at City College of San Francisco.

10.

Technical Assistance

The SFHN-BHS has identified several technical assistance needs:

1) Strategies for integrating the use of ASAM level of care criteria within professional practice through workforce skill building and accountability;

2) Strategies for fidelity management of evidence-based practices being implemented under the DMC-ODS Pilot;

3) Strategies for integrating a team-based care model within SUD treatment programs that includes primary care, mental health, and peer support as part of the client treatment, recovery and aftercare/discharge planning process;

4) Strategies for developing standardized county treatment protocol and payment mechanisms to ensure the treatment needs of out-of-county clients are met while reducing financial risk to treating counties.

11.

Quality Assurance

Overview and Quality Assurance Goals

The SFHN-BHS is committed to the provision of quality behavioral health services to all of its members. The SFHN-BHS provides and is responsible for a wide range of services to improve the health and promote quality of life for its clients. The scope of the Quality Management system within the SFHN is comprehensive and addresses the quality of clinical care, as well as its availability, accessibility and coordination.

The Quality Improvement plan includes the elements outlined by DHCS for DMC/ODS pilot. These include:

- Timeliness of first initial contact and face to face appointment
- Timeliness to first dose of NTP services
- Access to care after regular hours
- Effectiveness and response by the beneficiary access line
- Reducing care-sensitive hospitalization
- Coordination of DMC/ODS services with physical and mental health providers
- Assessment of consumer experience
- Language capability of telephone access line and all services in our five threshold languages.

The goals for the SFHN-BHS Quality Management (QM) System are:

1. To assure that services are community-based, consumer-directed, culturally competent and outcomes-focused.

2. To assure that services meet State requirements and standards of practice.

3. To assure that opportunities to improve care are identified.

4. To assure that the identified improvement opportunities are planned, implemented and evaluated.

5. To assure that QM activities and findings are communicated to participants.

6. To assure that fiscal, administrative and service procedures are in compliance with local, state and federal regulations.

QM Structure

The QM system structure is designed to satisfy regulatory and organizational requirements and to oversee processes that will result in improved consumer care. The work of the QM system is organized into quality improvement activities which are overseen by the quality improvement committees and various quality management support functions. Both the quality improvement processes and quality management support functions are described below. The QM system reports to the local behavioral health director.

Quality improvement processes are designed to obtain input from all participants in the systems of care, including consumers, family members, providers, administrators and the general public. Licensed mental health clinicians, the SUD Medical Director and SFHN SUD staff are involved in all QI processes. Consumers and family members, in particular, are given opportunities for input

on all aspects of quality management, participating at the highest level of QM decision making and policy development in the System of Care Quality Improvement Committee. Quality Management's work and activities are integrated with the System of Care, Access, and Compliance sections. All providers are required to participate in QM system goals and processes. Their input is a key component in the development of quality management policy.

Quality Improvement Committees (QICs) are organized to achieve QM goals and objectives and are founded upon a continuous quality improvement process. Their focus is on the consumer-provider relationship and includes review, analysis and response to risk management events, clinical outcomes, consumer satisfaction and complaints.

The Quality Improvement structure is comprised of the following committees which are responsible for the evaluation and improvement of the quality of mental health care rendered in facilities operated by the SFHN-BHS and in facilities providing care under contracts with the SFHN-BHS. The committees are:

1. System of Care Quality Improvement Committee (SOC-QIC) – see Appendix A for a list of members

2. Adult/Older Adult Quality Improvement Committee

3. Children, Youth and Families Quality Improvement Committee

4. Risk Management Committee

5. Medication Quality Improvement Committee

6. Client Council Quality Improvement Committee

7. Provider Quality Improvement Meeting

The reporting structure for these committees can be found under Appendix B.

<u>QM Oversight</u>
The SFHN-BHS System of Care Quality Improvement Committee (SOC-QIC) includes the SFHN-BHS Executive Team (senior managers), consumer and family representatives, and members of the QM staff. This includes the SFHN-BHS Director; SFHN-BHS Deputy Director; Adult/Older Adult and Children, Youth, and Families SOC Directors and Assistant Director; SFHN-BHS Medical Director; Medical Director of Quality Improvement; Pharmacy Director; Director of Quality Management; County SUD Administrator and Medical Director; Senior Information Systems Manager; Director of Mental Health Services Act Programs; Director of Behavioral Health Access; Director of Health Equity, Cultural Competency, and Workforce Development; Director of Research and Evaluation; Risk Manager, and SFHN-BHS Quality Improvement Coordinator. The Committee is chaired by the SFHN-BHS Director of Quality Management. A list of current members can be found under Appendix X.

The SOC-QIC performs following functions:

1. Serves as the oversight body for QM and provides QM policy advisement to the SFHN-BHS administration.
2. Reviews the functioning and efficacy of the QM structure to ensure that processes provide for program and system cohesion, reporting and accountability.
3. Provides a forum for receiving feedback about the quality of services provided to clients by consumers, family members, and specific family and consumer constituency and advocacy groups. This will occur through specific meetings with the SFHN-BHS Client Council QI Committee and the Mental Health Board.
4. Reviews system data collection activities, grievance and complaint procedures, and consumer outcome and satisfaction surveys.
5. Involves consumer and family members in specific subcommittees, task force groups, and other ad hoc efforts to address specific issues related to quality care.
6. Develops an annual work plan to evaluate system objectives and activities and to address potential areas relating to QM functions.
7. Oversees the collection and analysis of data related, at a minimum, to the following areas:
   a) Consumer clinical outcomes
   b) Consumer satisfaction
   c) Service access
   d) Service capacity
   e) Quality improvement documentation and case review
   f) Utilization Management
   g) Grievances
   h) Risk Management
   i) Clinical Guidelines, Standards, Policies and Procedures
8. Produces an annual report whose purpose includes an analysis of system status and identification of relevant and meaningful clinical areas that are in need of improvement or correction. Identified problems and needs will form the basis for the annual plan. This report shall also evaluate how Quality of Care has been improved as the result of QI activities.
9. Designates the responsible party or committee to execute the planned improvements with specific parameters and timelines for reporting the results of its work.
10. Periodically monitors and evaluates the annual work plan's effectiveness.
11. Assures that QI activities include measures and processes that assess the cultural competence of the System of Care.
12. As the need arises, creates new or ad hoc committees to satisfy achievement of the QM goals and objectives.

13. Builds Continuous Quality Improvement competencies through the provision of training and coaching to management and providers.

QM Processes and Indicators

The following processes and indicators provide a mechanism for the QM system to review, evaluate and plan improvements in care. Each of these indicators are reviewed at least annually by the appropriate QIC (see above).

1. Quality of Care Reporting System

   A critical function of the Quality Improvement System is to analyze risk data through various measures, one of which is the Quality of Care Reporting System (QOC System). Under the QOC System, each provider of services (whether civil service or a SFHN-BHS contractor) is required to report unusual or critical incidents that may affect the quality or adequacy of care. The appropriate committee or committees of the Quality Improvement Committee system review and analyze the incidents reported through the QOC System, providing an opportunity to identify and correct problems involving the quality of care rendered to clients. The SFHN-BHS Director adopts policies and procedures governing the operation of the QOC System.

   A designated QM staff member, overseen by the SFHN-BHS Director for Quality Management, is responsible for investigating, cataloguing and referring all Quality of Care reports to the appropriate QI committee or subcommittee.

2. Documentation/Peer Review

   The QI committees shall have access to relevant clinical records to the extent permitted by state and federal laws. This function provides the QM system with a process to review routine care at individual and system wide levels. QI reviews are conducted on a sample of client charts using a standardized protocol to evaluate compliance with clinical standards, documentation compliance, utilization and authorization guidelines, and client outcomes. These reviews may be conducted in a peer review or administrative review format. The results of an individual review are provided to the provider with requests for plans of correction when needed. Specific review of the safety and efficacy of medication practices shall occur under the supervision of a psychiatrist.

   The above documentation/peer review data is aggregated on an annual basis by QM staff in collaboration with the System of Care and Compliance Unit, overseen by the SFHN-BHS Director of Quality Management, and reported to the appropriate QIC. It is the responsibility of the relevant QIC to monitor the data for trends and to respond to any issues that have not been resolved at the staff and program level. The SOC QIC reviews and coordinates activities across the age groups and make an annual report to the SFHN-BHS Executive Committee.

3. Clinical Guidelines and Pathways

   Based upon system inputs (e.g., outcomes data, utilization of services), QM may collaborate with the System of Care to develop general guidelines and recommendations regarding clinical pathways for interventions. These efforts are undertaken in the service of quality management goals and objectives. In developing these guidelines and recommendations, QM staff include in the development process providers appropriate to the clinical arena (e.g., Children's services) or components of the QM system as appropriate (e.g., Medical

Quality Improvement Committee). Any guidelines and recommendations developed fall within the following parameters:

a. They should be specific to clinical presentations, rather than diagnostic category.

b. The factors related to clinical presentations should consider behavior and level of impairment in functioning.

c. They should be integrated with the modality of services (e.g., Residential Care).

d. They should specify triggers for service need, expectation for outcome, and end points of service.

The development of general guidelines and clinical pathways for intervention is not intended in any way to impair, restrict or interfere with the authority and responsibility of the professional providing services to behavioral health clients to make medical decisions regarding those clients. Guidelines for treatment have not included ASAM criteria. Discussion is in progress on how this might affect existing guidelines.

The designated staff member(s), overseen by the SFHN-BHS Director of Quality Management, provides an annual report to the respective committee on progress related to guidelines and pathways development.

4. Clinical Outcomes

One of the crucial areas in understanding the short- and long-term impact of managed care on the Seriously and Persistently Mentally Ill (SPMI) population and the SUD population is the development and implementation of effective outcome strategies. Clinical outcome measures are completed at intake, annually, and at discharge for clients of all ages in both civil service and organizational contract providers. Quality Management is responsible for training and certification of providers on the identified outcome measures. Designated QM staff analyze outcome data regularly and provide reports back to providers on a quarterly basis. QM staff conduct monthly outcomes support teleconferences to discuss findings and troubleshoot data collection issues.

Outcomes reports are provided at least biannually to the SOC-QIC which reviews the results for possible areas for improvement. Identified needs for improvement are referred to the age specific QI committees, client council QI committee, and provider QI meetings to determine specific improvement actions. The SFHN-BHS QI Coordinator facilitates gathering input from these committees and formulates an improvement plan based on outcomes.

5. Consumer Satisfaction

Consistent with the focus on outcomes, QM participates in the statewide effort to measure consumer satisfaction. All SFHN-BHS civil service and organizational contract providers participate in consumer satisfaction measurement efforts. The results of satisfaction survey efforts are reported to individual programs and become a routine part of program review.

Data is aggregated system-wide and reported to both the respective QIC and the SOC QIC. The SOC-QIC reviews and analyzes the data and to plan for necessary improvements.

The SOC -QIC, or its designee, is charged with informing all program providers of the result of consumer satisfaction survey efforts on an annual basis. Likewise, programs that have excelled in the area of consumer satisfaction are recognized and commended by the SOC QIC.

The designated staff member(s), overseen by the SFHN-BHS Director of Quality Management, provides an annual report to the respective committee related to Consumer Satisfaction activities.

6. Utilization Management

The primary function for QM within the Quality Improvement Utilization Review process is to ensure the provision appropriate service level and intensity of care. QM participates in the Utilization Review/Treatment Authorization Request process by evaluating and monitoring adherence to standards and guidelines in concert with the System of Care and Access system.

The components of the SFHN-BHS Utilization and Authorization processes include:

- All authorization and utilization review functions shall be supervised by a licensed mental health practitioner.
- Authorization decisions shall be made by licensed or waivered staff.
- Requests for services will include appropriate and relevant assessment documentation which is maintained in the client's chart. SFHN-BHS shall conform to State requirements regarding assessment documentation.
- The request for service will be recorded on an authorization and plan document which includes substantiation of medical necessity.
- Service authorizations shall be made in a timely manner.
- All service approvals and denials shall be substantiated.
- Provider and client shall receive written notice with explanation of denials.
- All providers will be informed of the required criteria and procedure for services. As requested, consumers and family members shall be provided written information regarding the authorization process. Both providers and consumers shall be informed of the usual grievance procedure and/ or notice of action in the instance of a service denial.

A designated QM staff member, overseen by the SFHN-BHS Director of Quality Management, makes an annual report of the timeliness of authorization decisions, rate of

denials and results of consumer or provider appeals to the SOC-QIC. On at least an annual basis, QM surveys consumer and provider satisfaction with access and the authorization process.

7. Problem Resolution Processes

   The Problem Resolution procedures are designed to review complaints about providers, access to services and requests for a change in providers, among other issues of concern to beneficiaries. It is the SFHN-BHS policy and practice to resolve consumer complaints at an informal level as quickly and as simply as possible. For complaints that are not resolved at an informal level, consumers or family members are given the option to initiate the grievance process.

   Grievances are submitted to the SFHN-BHS Grievance Officer for review. An acknowledgement of the grievance is mailed to the grievant within 24 hours of receipt. The Grievance Officer assigns the grievance to a QM investigator. The grievant is contacted during the investigation, and a final determination on the grievance is completed within 60 days of receipt. This process does not prohibit a consumer from utilizing other avenues of grievance.

   All providers of SFHN-BHS funded services are required to comply with the problem resolution and grievance process.

   A designated QM staff member (the Grievance Officer) is assigned to collect and review grievances. All grievance documentation is collected, summarized and reported to the respective QIC. The SOC QIC receives an annual summary of grievance activity. The SOC QIC monitors grievances for system-wide trends and plan for necessary quality improvement.

   Medi-Cal related complaints and grievance management are not completely integrated in SFHN-BHS QM, as the regulations and requirements for managing and reviewing are different between specialty mental health and DMC. Under DMC-ODS, the SFHN-BHS expects to explore areas of common procedure that could be further developed.

8. Program Performance Review

   Contracts with all providers clearly outline quality improvement expectations and functions. Assurance and compliance with such functions is the responsibility of the provider's program monitor. A periodic program review includes an evaluation of the provider's quality improvement work. The SFHN-BHS currently conducts an annual review of each of its direct provider and contract services. The review includes quantitative measures of contract compliance with service delivery, consumer satisfaction and compliance with submission of reports. A summary of program performance reviews is submitted to the San Francisco Health Commission, an external DPH governance body.

   Quality Management collaborates with the Business Office of Contract Compliance (BOCC) and the System of Care in the development of program performance objectives and calculates performance results annually. A designated QM staff member provides the

respective QICs with an annual summary of program performance. QM collaborates with the BOCC in the conduct of on-site program review visits and provides input into program plans of action when performance does not meet identified standards.

9. Service Capacity
   Quality management maintains a list of its service providers by modality, number, geographic location, and cultural, linguistic and clinical specialization.

   Quality Management staff assess capacity within the overall system of care. The goal of this assessment is to ascertain the adequacy of capacity related to demand, clinical specialization, service modalities, cultural need, geographic need and other areas of specialty focus. The relevant QIC reviews this data, identifies areas of need, sets goals and plans appropriate strategies to meet the service need.

10. Access
    Quality Management evaluates consumer and provider satisfaction with access, consistency of authorizations, results of the grievance procedure related to access, timeliness of assignment to service, responsiveness of 24-hour telephone access and response to requests for urgent conditions.

    The results of the Access evaluation are presented to the SOC QIC on at least a biannual basis. A designated QM staff member, under the supervision of the SFHN-BHS Director of Quality Management, collects and reports this data. Based upon a review of this data, the SOC QIC provides the Access and System of Care components with recommendations regarding access and service deficiencies.

    The San Francisco BHD QI work plan report from 14-15, and the work plan for 15-16 are attached as appendix E and F.

12.

Evidence Based Practices

The SFHN-BHS funds training and technical assistance for the evidence-based practices (EBPs) identified under the DMC-ODS Pilot including Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, and Seeking Safety (psycho-education for Post-Traumatic Stress Disorder and Addiction). In Fiscal Year 2015-16, each SUD treatment provider will be required to certify that SUD treatment staff are trained in at least two of the above EBPs. The SFHN-BHS will monitor provider compliance with this requirement through training sign-in sheets, regular provider meetings, and compliance site visits. Beginning in FY 2016-17, an EBP contract objective will be included into SUD treatment provider contracts. In addition, the SFHN-BHS will consider strategies in partnership with treatment providers for monitoring EBP model fidelity to ensure practices are implemented in the manner in which developers intended.

For those SUD treatment providers found non-compliant with the EBP requirement, a corrective action plan will be developed and monitored. Repeated failure to comply may result in the termination of a provider contract.

Through the support of a Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed System of Care grant, DPH is the lead county agency for the Bay Area Trauma Informed Systems of Care (BATISC) initiative which includes a regional collaborative of seven Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara and Santa Cruz. The initiative focuses on creating a trauma informed region in order to reduce disparities in behavioral health access and improve the provision of trauma-informed services. Under the SAMHSA grant, DPH has developed a Trauma Informed Systems (TIS) Framework intended to help improve organizational functioning, increase resilience and improve workforce experience that includes the following components:

- Mandatory, foundational training to all 9,000 public health employees and contractors, including SUD treatment providers, to create a shared language and understanding of trauma for our workforce;
- Development of an embedded Champions Learning Community (CLC) to support, apply and sustain the application of the TIS principles and practices into the entire DPH workforce;
- Train the Trainer program to embed and harness trauma expertise with in our system and establish a permanency of the initiative;
- Intentional efforts to align TIS with all our workforce and policy initiatives to insure TIS implementation increases coherence, unifies our system and improves outcomes;
- Leadership engagement and outreach to support leaders to integrate TIS principles into day-to-day operations as well as promote system change at the program and policy level;
- Establishment of San Francisco as a Trauma Informed City ensuring that the entire workforce has a common language and principles.

During Fiscal Year (FY) 2014-15, all SUD treatment staff were required by DPH to be trained in TIS to create a shared language and increase the understanding of trauma among the behavioral health work force. As a next step in this system-wide effort to infuse TIS principles within SUD treatment work, in FY 2015-16, contracted SUD treatment providers will receive technical assistance and training on strategies to embed TIS principles within clinic day-to-day operations and SUD treatment services.

13. Assessment

ASAM Standards of Care and Placement Criteria

Below are the key stages where ASAM will be integrated in the treatment intake, treatment planning, and care transitions/discharge process.

Referral & Admission

- Client initial interview conducted to establish eligibility for admission
- Client medical and drug history recorded and SFHN-BHS health questionnaire completed
- Client TB/co-occuring disorder sceening
- Client admitted to treatment

Intake & Assessment

- Client DSM 5 Diagnoses and medical necessity established by licensed provider.
- Client assessed for immediate needs due to imminent risk in any of the ASAM Multidimensional Assessment assessment dimensions: 1) Acute Intoxification and/or Withdrawal Potential; 2) Biomedical Conditions and Complications; 3) Emotional, Behavioral, or Cognitive Conditions and Complications; 4) Readiness to Change; 5) Relapse, Continued Use, or Continued Problem Potential; and/or 6) Recovery/ Living Environment
- Special population priority access determined (pregnant women and injection drug users)
- Determination of where services can be provided in the least intensive but safe level of care - level of care placement

Treatment Planning

- Client's ASAM multidimensional severity/level of function profile created with client's most important assessment dimensions identified to inform treatment priorities
- Specific focus and targets for each priority dimension determined - client needed dose/intenstity of services identified for each dimension - withdrawal management in initial and updated treatment plans
- Medical necessity established by licensed physician
- Continual monitoring of the treatment plan progress for placement decisions - outcomes measurement
- Continued need for services reviewed and medical necessity established by licensed physician

Care Transitions & Discharge

- Client transitioned to lower level of care (client reassessed for ASAM dimensions at transition) OR
- Client relapse triggers and strategies for addressing triggers identified in discharge plan
- Client reassessed by primary care or behavioral health home for recovery maintenance

The SFHN-BHS will work with SUD treatment providers and DHCS to develop and implement strategies to fully integrate the use of the ASAM Multidimensional Assessment across all levels of care under the DMC-ODS Pilot.

Medical Necessity

All SUD treatment providers, regardless of a client's level of care placement, will assess each client for medical necessity at intake/admission, during initial and updated treatment plan development, and for continued service authorizations.

Medical necessity will be established when a client is diagnosed with a substance use disorder based on the Diagnostic and Statistical Manual (DSM) of Mental Health Disorders, with the exception of nicotine use disorders. Medical necessity also may include a physical examination and laboratory testing by staff lawfully authorized to provide these services.

Licensed practitioners of the healing arts (LPHA) acting within the scope of their respective practices may evaluate whether a client has a substance use disorder.

For clients accessing treatment services through the Howard Street Program TAP or contracted SUD treatment providers, the table at the top of the following page shows key treatment milestones where medical necessity is established.

Correct Placement Level

For non-residential SUD treatment providers, client placement decisions will be made in partnership with clients and other providers using information gathered through client personal, medical and substance use histories, intake and admissions, and treatment process. This includes continual monitoring of client progress toward treatment goals within deadlines prescribed by DMC (Title 22) and for NTP (Title 9) to inform transitions through levels of care, as well as discharge planning.

For SUD residential treatment providers, the ASAM Criteria Multidimensional Assessment crosswalk will be used in making level of placement decisions in partnership with clients and members of the treatment and transitions team. Please refer to ASAM grid under Appendix A.

14. Regional Model

While a regional model is not being utilized by Phase I counties under the DMC-ODS Pilot, Bay Area counties have been engaged in regular discussions during the development of county implementation plans as noted earlier. There is a commitment on the part of Bay Area counties to engage in discussions about future collaboration.

As noted in previous sections of the county implementation plan (Section 3 – Treatment Services and Section 11 - Evidence Based Practice), one promising forum for beginning a dialogue on greater regional collaboration is the Bay Area Trauma Informed Systems of Care initiative led by DPH. As the regional infrastructure is strengthened, it is in the intention of DPH-SFHN to engage county partners in a dialogue on promising practices across the region for trauma informed SUD treatment services that could be leveraged as a learning resource for treatment providers and other community stakeholders to improve treatment access, quality and effectiveness, as well as the treatment work force.

In addition, the Children, Youth, and Family System of Care under SFHN-BHS currently collaborates with Bay Area counties, as well as other placement counties, to ensure children, youth and transition age youth involved in the child welfare system have timely access to needed behavioral health services (*Katie A.*). This collaboration may have potential for regional approaches to care.

This collaboration regarding youth in foster care is part of a regional Bay Area Trauma Informed System grant from SAMHSA. This effort is led by Dr. Ken Epstein, (Kenneth.epstein@sfdph.org.)
Here are some details from San Francisco report to 2014 EQRO:

I. Trauma Informed Systems Initiative

The Trauma Informed Systems Initiative Workgroup is led by Dr. Ken Epstein, Director of our Children, Youth, and Families System of Care, and is currently staffed by a full-time Coordinator, a team of 4 interns, a work group of subject matter experts, and the support of the Community Behavioral Health Services Training Department. The Initiative has based its change efforts on the Trauma Informed System's Six Principles and Competencies developed by the work group: 1) Trauma Understanding, 2) Cultural Humility & Responsiveness, 3) Safety & Stability, 4) Compassion & Dependability, 5) Collaboration & Empowerment, 6) Resilience & Recovery. These principles provide the framework for the foundational training curriculum, as well as the starting place for considering our staff-to-staff relationships, and our programs and policies. The workgroup, made up of BHS staff and other DPH employees, is leading this change effort, which includes the following components:

* Mandatory, foundational training to all 9,000 public health employees to create a shared language and understanding of trauma for our workforce.

* Development of an embedded Champions Learning Community (CLC) to support, apply, and sustain the application of the TIS principles and practices in the entire DPH workforce.

* A Train-the-Trainer program to embed and harness trauma expertise within our system and establish a permanency of the initiative.

* Intentional efforts to align TIS with all our workforce and policy initiatives to insure TIS implementation increases coherence, unifies our system, and improves outcomes.

* Leadership Engagement and outreach to support leaders to integrate TIS principles into day-to-day operations, as well as to promote system change at the program and policy level.

Workforce Training: After extensive vetting, the TIS half-day, interactive training was piloted on

II. Katie A. (Interagency Services Collaborative- IASC)

The San Francisco Health Network and Human Services Agency (HSA) are collaborating to promote the health, safety, permanency and well-being of children, youth and families in, or at imminent risk of, placement in foster care. This will be accomplished by making fundamental changes to design a coordinated children's service system of care that is attachment-focused, resiliency-based, and trauma- informed. The intention is for these changes to lead to service system improvements that help to strengthen families and increase the number of children who remain in their homes, are reunified with their parent(s), or are permanently placed with families.

In order to effectively test and spread change across our systems, we are using PDSA (Plan, Do, Study, Act), which is a quality improvement method designed to effectively build change into large systems rapidly. We are working toward the following goals:

* Reduce the time it takes to screen and assess at-risk and dependent children for medical necessity utilizing a one page CANS, and increase efforts to support and engage with children and families at first point of contact. Progress toward this goal has been steady. In partnership with HSA Protective Service Workers and Supervisors, the Foster Care Mental Health (FCMH) Behavioral Health Clinicians, Mental Health Consultants and Supervisors have streamlined the referral process. Since February 2014, FCMH has received a total of 818 new referrals for CANS

Screens: Of these, 421 referrals were for newly detained children. All have been screened or fully assessed by either FCMH, a CBO Contractor, or Civil Service Clinics. The use of the one page CANS have greatly improved our ability to reach more children in a reduced amount of time.

* Facilitate timely Child and Family Team (CFT) meetings that actively engage the family, the child welfare worker, and the mental health clinician. Using a collaborative decision making process, our County decided that the Child and Family Team Meetings would be "owned" and facilitated by HSA trained facilitators. All CFT meetings are called by the Court Dependency Unit (CDU) or Family Maintenance Protective Social Worker (FM PSW), scheduled by HSA schedulers. The invitation is extended only to the Mental Health Consultants, Peer Parents, and PSWs. The feedback from our PDSA tests suggests that the CFTs are more useful to the PSWs if the CANS is completed before the CFT is held. However, anecdotally, we have found that the Parents find the CFT helpful to discuss their behavioral health concerns related to themselves and

their children, whether or not the CANS screen has been completed. The presence of the mental health consultant has been very helpful for the Parent and the PSW.

* Assign a Care Manager in the Child and Family Team Meeting that maintains consistent contact with the child and family throughout their foster care stay. Beginning in August, 2014, FCMH restructured itself to better meet the needs of the hundreds of children and families we serve. We are now working in multidisciplinary groups of case managers, clinicians and mental health consultants. Each group, called a "Pod," led by a lead clinician, is responsible for screening to determine eligibility and medical necessity, attending the CFT meeting, and linking the child and family to services. The Pod that the child is referred to will stay connected to the child and family throughout their contact with the HSA Child Welfare System. The Pod will manage all mental health referrals, including Utilization Review and authorization for each child and family within their collective care. In this way, FCMH will provide long term, attachment based, trauma informed care coordination.

* Develop Shared (Family, Child Welfare, and Mental Health) Care Plans, including shared formulation.

* Design and offer Shared Case Consultation and Coaching for the Child Welfare and Mental Health team. Just as we used PDSAs to test out the One Page Screening CANS and to test the CFT meetings, we will now begin to use PDSAs to test out Shared Care Planning. Through the use of a Reflective Coaching Practice, the same teams of providers who tested CFTs will now test Shared Care Planning. HSA supervisors, directors, as well as Behavioral Health supervisors and directors will also participate in this practice improvement transformation. Through a collaborative process, our teams created a form that will be used to test how the results from the CFTs will become an integral part of the Child Welfare Case Plan. Cohorts of providers have already been formed and we will begin our next PDSA in February 2015.

The goals of this practice improvement effort are:

* To have one plan for one family in order to decrease confusion for families;

* To have a shared understanding and language related to physical, environmental, psychological and emotional safety of children;

* To increase ongoing collaborative, trusting communication and relationships between Behavioral Health providers and HSA Protective Services Workers and supervisors in order to better serve our families.

15.

Memorandum of Understanding

A Memorandum of Understanding (MOU) was executed in May 2015 between the Chief Executive officer for the San Francisco Health Plan, the Director of Behavioral Health Services for the San Francisco Department of Public Health, the Director of the San Francisco Department of Public Health, and the San Francisco City Attorney with regard to specialty mental health services. A copy of the draft amended MOU which now includes DMC-ODS services required under the DMC/ODS can be found under Appendix D.
A similar MOU is in process with Anthem Blue Cross, the only other Medi-Cal health plan. Since revisions are amendments, we expect approval to be timely, occurring by March 2016.

Sharing of information and case consultation details between systems is currently limited by Part 2j privacy requirements; we are in process of working on how to share de-identified information for quality management purposes between plans. We have requested TA on regarding this issue.

Up to now, DMC services had to be provided only face to face in DMC certified locations. Navigation within SUD now includes enrollment navigators for uninsured persons who present for SUD services. We are considering adding peer navigation, following mental health model. BHS has certified peers working in the mental health plan. Some of those peers are also certified drug counselors, and at times have been employed as drug counselors by our contracting providers.

16. Telehealth Services

The SFHN uses telemedicine to connect primary care to specialties. Teledermatology and teleretinopathy, as well as telepsychiatry, are currently in place.

Telepsychiatry is a joint effort between the SFHN-BHS and SFHN Primary Care. A psychiatrist consultation can be requested by the primary care provider. Usually there is a discussion between providers about the patient, sometimes also a client interview. Limited participation in telepsychiatry by addiction medicine consultant has occurred in the context of a primary care physician using buprenorphine to treat opioid use disorder in a patient with psychiatric comorbidity. The current SFHN-BHS telehealth services are limited to SFHN civil service clinics and are not available to SUD contracting partners. In view of the compact geography of the City and County, development of telehealth for SUD services is not a high priority at this time.

17. Contracting

The DPH Office of Contract Management and Compliance is responsible for executing and monitoring SUD treatment services contracts working in close partnership with the County Alcohol and Drug Administrator and Director of Behavioral Health Services. The SFHN-BHS specifies desired contractor qualifications, service modalities, priority populations and neighborhoods within San Francisco, and client outcomes during the Request for Proposal process. Each RFP incorporates an appeals procedure.

Contracts are awarded through a competitive bid process on multi-year award cycle subject to satisfactory performance and the availability of funding. Each fiscal year, contractor negotiations occur to develop contractor scopes of work, performance goals and rates. In unusual cases, mid-year contract amendments are used. The multi-year award is of variable length, usually five years, but each contract is a year long and negotiated yearly. If a contract is not renewed, the county works with the existing provider to place each client in contracting programs.

It is expected that current contractors in good standing will submit proposals to continue to provide SUD treatment services under the DMC-ODS contract as many are currently in the process of meeting requirements such as training staff on ASAM Criteria and obtaining DMC certification. In addition, the SFHN-BHS is committed to continue collaboration with its provider network of community based treatment providers to ensure that technical assistance, training, and a community professional learning continues to be facilitated.

18. Additional Medication Assisted Treatment (MAT)

The SFHN-BHS promotes alcohol medications as an additional Medication Assisted Treatment to support client recovery and prevent relapse. These include Naltrexone, Acamprosate, and Disulfiram in SUD treatment programs and the off-label use of Topiramate in primary care and mental health treatment settings.

Alcohol MAT

- Alcohol medications including naltrexone, acamprosate, disulfiram, and off-label use of topiramate. Naltrexone is used more for alcohol than for opioid use disorder; however it is also available for opioid use disorder, and listed as an alternate treatment medication in OTP treatment consents.

Methadone MAT

- Three (3) methadone outreach vans
- Seven clinics contract with 25 programs.
- Continued treatment in jail
- Enhanced perinatal support
- Maintenance and detoxification
- Hospital starts
- Primary care methadone OBOT
- Facilitated entry from outreach to homeless
- Centralized after-hours intake

Naloxone MAT

- Pilot project for police officers to carry naloxone
- Community naloxone and syringe distribution

Buprenorphine MAT

- Integrated buprenorphine model into primary care and mental health clinics
- Support for buprenorphine induction at Howard Street Program
- BHS Pharmacy contributes observed dosing and medication advice by specialized clinical pharmacist
- BHS pharmacy provides medication for uninsured patients and for OBIC patients during stabilization
- Buprenorphine “starts” in jail
- Hospital buprenorphine “starts” with expedited placement at Outpatient Buprenorphine Induction Clinic
- Hospital naltrexone starts/brief interventions for hospitalized patients who have alcohol withdrawal management – continuation in primary care upon discharge
- Buprenorphine integrated into residential care and residential detoxification.
- Under DMC/ODS buprenorphine also become an NTP required service

Naltrexone MAT:

- Hospital starts for any person who required inpatient alcohol detoxification, with

continuation in primary care or mental health outpatient settings

- Injected naltrexone pilot for alcohol has been carried out, and system application is planned for DMC/ODS. Currently we do not provide injected naltrexone prior to release from services with institutional abstinence, but we may do so depending on results and recommendations from this pilot.

- Naltrexone MAT is offered upon NTP or residential treatment admission as one of the options for opioid use disorder treatment.

19. Residential Authorization

The Howard Street Program Treatment Access Program screens, assesses, and authorizes residential treatment placement for clients with SUD. Following is a description of the TAP treatment authorization protocol along with a visual diagram.

Howard Street TAP Residential Authorization Protocol

1. The client presents at, or is referred to, TAP seeking SUD services. Usually seen the same day or at most 72 hours later, in case of referral on weekend. Urgent cases are referred to off hours services if TAP is not in service. The 120 day limit for interim services is taken from SAPT, however no one has waited that long for residential, and we expect correct ASAM placement to be within 15 days under the waiver. Although total wait from first contact is not currently well tracked, review of TAP tracking sheet from first contact suggests current average wait of 20-30 days. Under the waiver, shorter reauthorization span and treatment time limit, along with case management to fill beds more promptly will allow shorter wait.

2. The Medi-Cal Eligibility Data System (MEDS) is accessed to determine current Medi-Cal status. Clients without San Francisco Medi-Cal are routed to the on-site Medi-Cal enroller for processing. Navigator support by peer enrollers is offered on site. Treatment is not delayed during the establishment of eligibility, but is not billed to DMC unless eligibility verified.

3. An initial screening and assessment of the client is conducted to identify co-occurring conditions that may also require clinical attention. In the case of serious mental health needs, mental health access workers on location at TAP are engaged.

4. A tuberculosis symptom review is conducted with all clients during screening.
    a. A client screening positive for symptoms of TB are routed to the program nurse practitioner who completes a thorough assessment and a tuberculin skin test (TST) is administered and/or the client is referred to San Francisco General Hospital TB clinic for follow up.
    b. Clients without symptoms of TB are screened prior to entry into residential treatment, either on-site at TAP, or by the program with the open residential treatment slot.

5. The ASAM Criteria will be administered for Level 3.1, 3.3, and 3.5 level of care placement, usually same day at TAP or at residential program intake site.

6. After meeting all required placement criteria, the client is immediately placed into an available residential treatment slot. Preference in admission to treatment is given in the following order:
    a. Pregnant injecting drug users
    b. Pregnant substance users

c. Injecting drug users
d. All others.

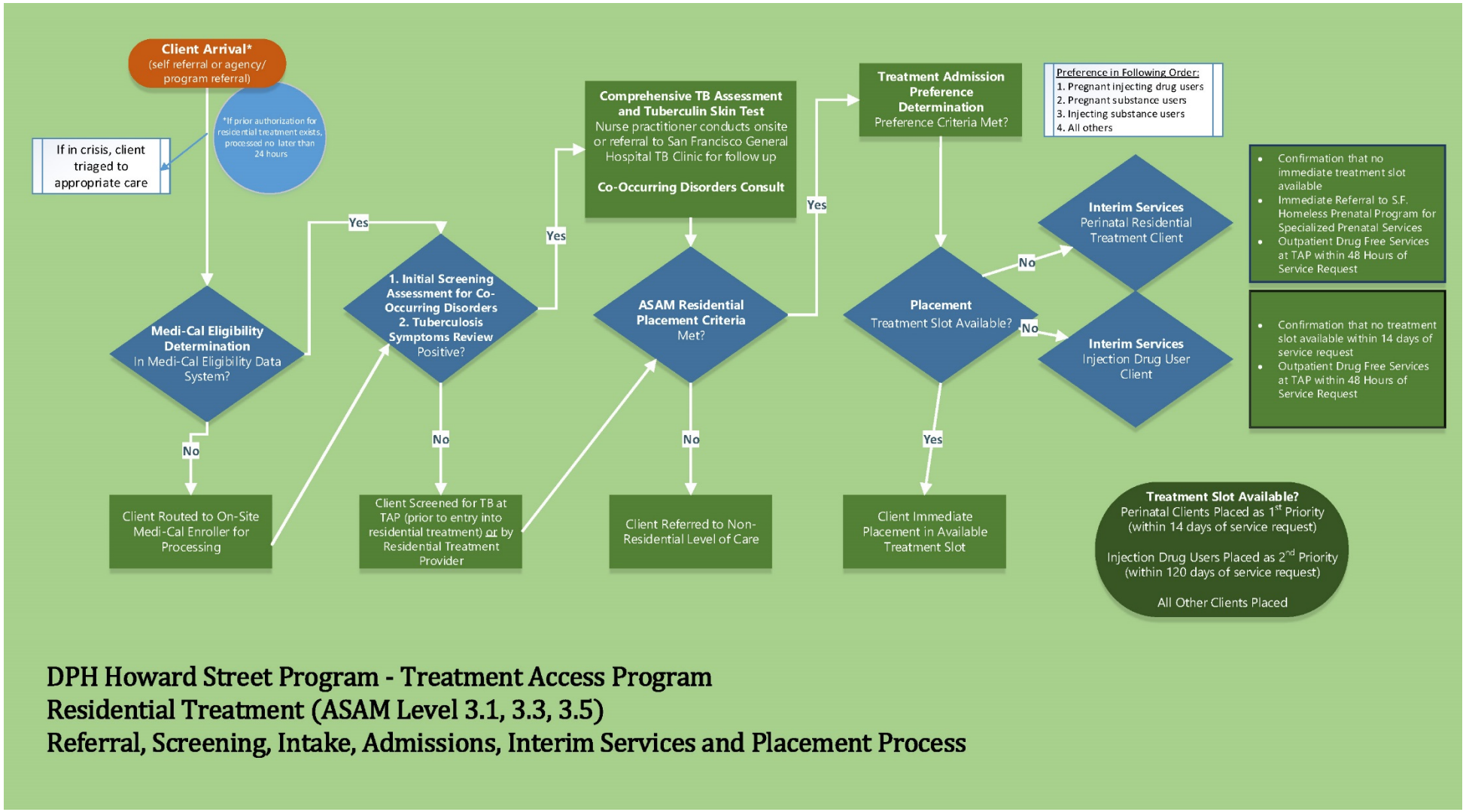
7. If immediate capacity is unavailable, the client is maintained on the program's internal Wait List Record (WLR).

8. Interim services, in the form of an outpatient modality, are provided to clients at TAP while awaiting entry into residential treatment and include the following provisos:

Pregnant Women	**Injection Drug Users**
• TAP, as the Centralized Authorization Site for perinatal residential treatment slots in San Francisco, has confirmed that an immediate placement into residential treatment placement slot is unavailable. • Clients are immediately referred to the San Francisco Homeless Prenatal Program for specialized prenatal services. Consents are obtained from the client. • Within 48 hours of their service request, the client is provided interim services at TAP.	• TAP has confirmed that a treatment slot is unavailable within 14 days of service request. • Interim services are provided at TAP within 48 hours of client treatment request. • If client participates in Interim Services, s/he will be admitted into treatment within 120 days.
Interim Services will provide individual and group education and counseling that includes, but is not limited to: TB, HIV and Hepatitis C; Risks associated with needle sharing; Modes through which transmission of HIV and TB can be prevented; Risks of disease transmission to sexual partners and infants; and Information on the effects of substance use on the fetus (pregnant women) A client who enrolls in an outpatient treatment program, including narcotic treatment programs, may still be assessed as appropriate for residential treatment, and therefore may stay on the waiting list for residential treatment. However, interim services are not required once the client has enrolled in any treatment program.	

9. Should a client disengage from interim services or decline treatment, they may be removed from the wait list. The 14 day and/or 120 day clocks are reset upon a subsequent treatment request.

Following is a visual diagram of the TAP treatment authorization process.



Although interim services are offered up to 120 days, average access to residential treatment is under 14 days, with most persons placed by 21 days. The SUD Treatment Demand report from 2015 showed that as of December 31, 2015 there were 31 available residential treatment slots, and 35 clients waiting for residential slots. Those who wait longer may be waiting for patient choice or neighborhood location, or culturally specific programs, and there is also sometimes a time delay between client notification and client registration at the program.

20. One Year Provisional Period

San Francisco will not participate in the one-year provisions program.

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

_____	_____	_____
County Behavioral Health Director*	County	Date

(*for Los Angeles and Napa AOD Program Director